Hospital Care for the Uninsured in Miami-Dade County

Hospital Finance and Patient Travel Patterns

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PREFACE

In response to continuing concerns over access to health care by the uninsured, the W. K. Kellogg Foundation in 1998 launched an initiative called "Community Voices." The goal of the initiative is to assist local organizations in strengthening community support services, giving the underserved a voice in the debate over health-care access, and identifying ways to meet the needs of those who now receive inadequate health care. One of the Community Voices grants went to Miami, Florida, where it is administered by Camillus House, a Catholic social service agency and health-care provider for the homeless.[1] Camillus House asked RAND to participate in the Community Voices–Miami project, to evaluate the five-year effort and to provide technical assistance. One aspect of the latter role was a request to investigate the flow of funds through Miami-Dade County hospitals, especially with regard to unpaid charges for care. In the course of conducting this analysis, it became clear that it was also necessary to analyze whether the funds-flow pattern was associated with where county residents receive care. This report presents the results of these two analyses.

[1]United Way of Miami-Dade was asked to join the effort to provide assistance with community outreach.

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SUMMARY

One-quarter of the population in Miami-Dade County, Florida, lacks health insurance, a fraction well above the national average (about one-sixth of the nation's population is without health insurance). To address the problem of financing health care for the uninsured in Miami-Dade and elsewhere, the state of Florida in 1991 passed legislation allowing local jurisdictions to impose a surtax on sales. The legislation restricted the use of the proceeds of any Miami-Dade County surtax to support the activities of the county's sole public health-care facility, Jackson Memorial Hospital (JMH). Miami-Dade County voters approved the surtax, which has helped stabilize the financially troubled hospital. In the past ten years, JMH has grown and improved financially and is a leader in treating eye disorders and pediatric patients. Recently, advocates for better access to health care by the poor, along with representatives from other not-for-profit hospitals, have suggested that surtax revenues be distributed across a wider range of institutions. But do hospitals other than JMH provide uncompensated care, and at what level? And might the greater access to surtax-funded care at JMH be causing patients to pass up facilities much nearer to their homes and travel long distances for care?

WHO PROVIDES UNCOMPENSATED CARE?

Analysts of hospital finances typically recognize two types of uncompensated care: charity care, which includes cases for which the hospital knows on admission that it is unlikely to be compensated, and bad debt, which includes cases for which payment may have been expected but none was made. The 24 general acute-care hospitals in

Miami-Dade County provided $404 million of charity care and incurred $250 million of bad debt in 1999. The $650 million in uncompensated charges represents $281 million in costs of uncompensated hospital care provided to county residents.

Of JMH's nearly $714 million in operating costs, charity care accounts for 23 percent, and bad debt accounts for another 2 percent (see Figure S.1). This estimate, however, ignores the $142 million received from the surtax. To the extent that JMH is being reimbursed by the taxpayers for providing charity care, the burden of that care on the hospital's operating expenses would be reduced. In recent calculations, the Florida Hospital Association has arbitrarily assumed that half of the surtax proceeds are devoted to indigent care and half are used for other purposes. If the half for indigent care is subtracted from the costs of charity care, net charity-care costs total 13 percent of operating expenses. The surtax legislation was motivated, however, by a desire to support indigent care, and in all other Florida

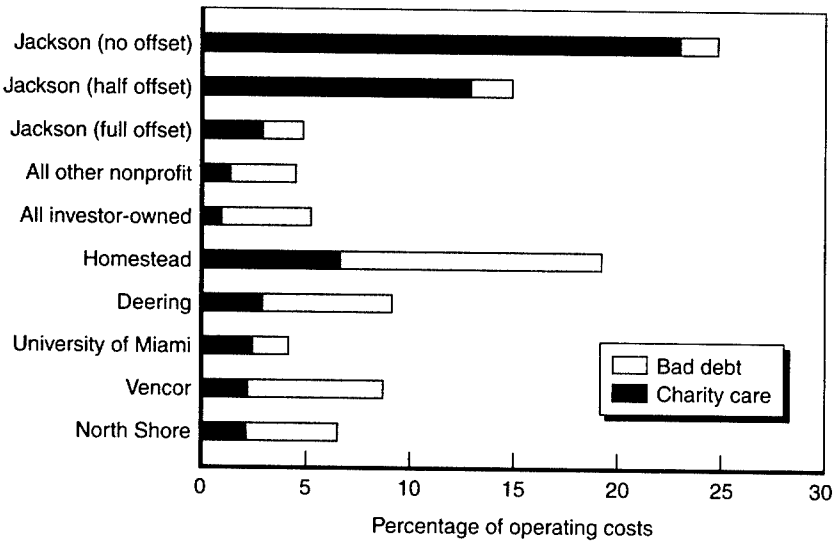

Figure S.1—Percentage of Operating Costs Used for Charity Care and Bad Debt at Selected Miami-Dade County Hospitals, 1999

counties it is restricted to that purpose. If all of JMH's surtax proceeds were regarded as supporting charity care, the costs for that care would be offset by the full amount of the surcharge. Charity care would then account for only 3 percent of JMH's operating expenses.

Regardless of how the surtax is used by JMH, charity care is a greater burden on operating expenses there than it is at the average not-for-profit or investor-owned hospital in Miami-Dade County. When bad debt is taken into account, however, the total burdens of uncompensated care are similar. Indeed, as a percentage of operating expenses, the burdens of charity care (and total uncompensated care) at some hospitals approach or even exceed those at JMH, but only if all surtax revenues are regarded as intended for indigent care.

This disagreement over the interpretation of the surtax legislation (i.e., how *much* of the proceeds were intended for indigent care) has caused a difference of opinion on whether and how the proceeds should be distributed. Some argue that if the surtax legislation was motivated by the need to support indigent care generally, the proceeds should be more widely allocated to offset the costs of that care. However, three arguments may be made against such claims: First, Florida's surtax legislation did not restrict the tax's use in Miami-Dade County to indigent care but did restrict it to JMH, so the law would have to be changed. Second, private not-for-profit hospitals should be returning some benefits to the community without receiving compensation, in return for their nonprofit status (of the hospitals other than Jackson shown in Figure S.1, only Homestead and the University of Miami Hospital and Clinics are nonprofit institutions). Third, the large bad-debt burdens at some hospitals may be due as much to bad fiscal management as they are to the need to write off care for patients who cannot afford to pay.

HOW FAR DO THE UNINSURED TRAVEL FOR CARE?

Is the greater availability of charity care at JMH (and the surtax offset permitting that availability) drawing uninsured patients away from hospitals closer to their homes? This is a question of some concern, since, other things equal, hospitalization near home is less burdensome to families, particularly poor families who may have to rely on public transportation.

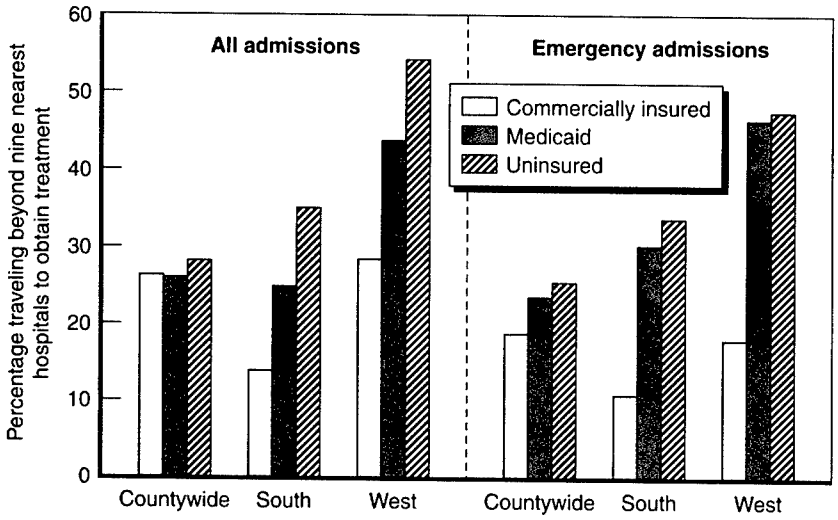

Figure S.2—Percentage of Adult Patients Traveling Beyond at Least Nine Hospitals to Obtain Treatment, Miami-Dade County, 1999

Across Miami-Dade County in 1999, approximately 40 percent of adult patients under the age of 65 were treated in the hospital nearest or second-nearest to their homes. There was little difference among commercially insured, Medicaid-insured, and uninsured patients.[1] Neither were there appreciable differences among these categories of patients in the percentage that traveled beyond at least the nine nearest hospitals to get treatment (see Figure S.2, first three bars). (Our travel analyses excluded patients traveling outside the county for care.)

Uninsured patients living farther from JMH, in the southern and western parts of the county, however, were more likely to travel beyond numerous closer hospitals to get care than were Medicaid patients, who were in turn more likely to travel beyond numerous

[1]In Figure S.2, all differences between pairs of bars within three-bar sets are statistically significant at the 5 percent level or above, except for commercial versus Medicaid, countywide (all admissions).

hospitals than were the commercially insured.[2] Even among those seeking emergency care, Medicaid and uninsured patients were more likely to travel farther than were the commercially insured, despite a state law requiring all hospitals to treat any emergency patient. This difference was not due to the case-mix of Medicaid and uninsured patients. Even when we restricted our analysis to cardiac conditions (other than heart attack), the findings were the same.

Children were less likely than adults to be transported past many hospitals to get care, as shown in Figure S.3.[3] However, those from the southern and western parts of the county who were transported farther were more likely to be uninsured than Medicaid-insured, and more likely to be Medicaid patients than commercially insured. Again, this finding held true even in emergencies.

Travel patterns are not necessarily the result of access limitations, however. They can reflect a patient's personal choice, recommendations by friends or family members, or the admitting privileges of the patient's physician. That is why we compared uninsured and insured persons, since any differences not related to insurance should average out across the large number of patients considered. It thus appears that patients who are not commercially insured, and particularly those without Medicaid, are being directed for care, either by their own volition or by the health care system, past numerous hospitals, even in emergency situations. Where are these patients going? When we look at the hospital destinations for those patients who travel beyond their local hospitals, JMH is the most frequent choice for uninsured and Medicaid patients. Commercially insured also go to JMH when they travel beyond the nine nearest hospitals for care, but they do so less frequently. Are more of the uninsured traveling to JMH because they feel they have greater access to the health-care

[2]We focus on the southern and western regions of the county, because residents there are unlikely to use hospitals outside of Miami-Dade County. Residents in northern Dade could easily cross into Broward County for hospital care, which would complicate a travel analysis.

[3]In Figure S.3, all differences between pairs of bars within three-bar sets are statistically significant at the 5 percent level or above, except for commercial versus uninsured and Medicaid versus uninsured, countywide (all admissions) and all comparisons, countywide (emergency admissions).

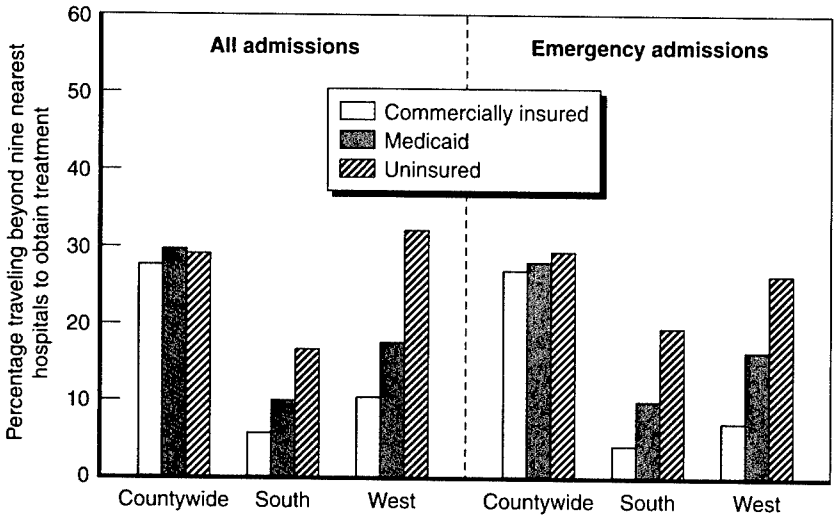

Figure S.3—Percentage of Pediatric Patients Traveling Beyond at Least Nine Hospitals to Obtain Treatment, Miami-Dade County, 1999

system there than they can get closer to their homes? That is an interesting question that deserves further investigation.

RECOMMENDATIONS

Our analysis suggests the following issues and policy options that might be considered by policymakers, stakeholders, and community members in Miami-Dade County.

Reduce the number of uninsured persons in the county.

- Increase the enrollment of persons into Medicaid and other state and federal programs. Much effort is currently being devoted to increasing enrollment for children.
- Expand Medicaid and other public programs to include more adults. Many uninsured adults are being hospitalized, and their lack of health insurance affects their geographic access to care. Undoubtedly, some of the patients whose care is uncompensated are eligible under the current Medicaid program or under allowed expansions. Some level of compensation is preferable to no compensation.

Revisit the financing of health care for the indigent.

- Reconsider the intent of the half-penny sales tax and, in light of this analysis and any other pertinent facts, either endorse its current allocation or seek ways to alter it. The $142 million in surtax is insufficient to cover the cost of uncompensated care provided by the county's 24 acute-care hospitals.
- Explore ways to increase the distribution of care and funds for care for the uninsured throughout the county. Policymakers should consider having the county provide or subsidize health insurance that would enable patients to obtain care wherever they choose, with the assurance that reimbursement will follow.

Consider the role of community benefits in the county and their impact on the provision of indigent care.

- Clarify the community's sentiment about specifying levels of community benefits that nonprofit agencies must provide. Does the county want to rely on the quid pro quo of tax exemption and provision of charity care to maintain the safety net? Miami-Dade County should consider explicitly detailing the level of community benefits it expects from nonprofit entities. How much charity care could be provided through a community benefits program?

Monitor the dynamics of hospital care provision in the county and publicize any changes.

- During the period in which these analyses were conducted, the Public Health Trust and the Jackson Health System purchased Deering Hospital, located in South Miami-Dade. This purchase will bring this hospital into the county system. Assuming that patients are well informed of this change, Deering should provide some relief for uninsured patients who currently travel long distances to JMH. It may also provide relief to Homestead Hospital, also located in the South Dade region, which provides a high level of uncompensated care. When data become available, analysis of the travel patterns in South Dade will show whether the introduction of another public hospital brings the expected relief to Homestead Hospital and to uninsured patients.

ACKNOWLEDGMENTS

We thank the members of the Multi-Agency Consortium and Oversight Team of Community Voices–Miami for their insightful comments on earlier versions of this report. Although it is impossible to acknowledge every individual's contribution, we benefited from detailed comments by several staff members of the Jackson Health System and by Hilary Hoo-you and Marty Lucia of the Health Policy Authority. They helped us develop a better understanding of the issues surrounding health care for the uninsured in Miami, and their input contributed considerably to the final version of the report.

We also thank our partners at Camillus House and the United Way of Miami-Dade County for their support of this work, and the W. K. Kellogg Foundation, which, through its support of Community Voices, made this report possible.

Formal reviews of the draft text were provided by John W. Colloton, Director Emeritus of the University of Iowa Hospitals and Clinics, and Geoffrey Joyce of RAND. Their comments and recommended revisions greatly enhanced the usefulness of the report.

We also appreciate the assistance of other RAND colleagues. Specifically, Marika Suttorp and Jennifer Sharp helped with the analyses contained in this report, and Amanda Beatty provided very helpful comments on a near-final version.

Our acknowledgments should not be taken to imply that the persons and organizations mentioned above endorse our approach and conclusions. The authors take full responsibility for all assertions and interpretations in this report.

Chapter One

INTRODUCTION

Health care for the uninsured continues to be a national policy problem, with recent estimates indicating that 42 million nonelderly Americans—nearly 18 percent of the total nonelderly population—are without health coverage.[1] Health insurance is an important determinant of access to health-care services.[2] Lack of adequate coverage can lead to poorer health outcomes (higher risk-adjusted mortality, preventable hospitalizations, higher inpatient mortality risk)[3] and puts individuals and families at risk for significant economic losses. Purchase of health insurance is beyond financial possibility for many, as evidenced by the fact that the poor and near-poor constitute almost two-thirds (65 percent) of the uninsured population.[4] In the end, society bears the cost of these losses, as providers, governments, and ultimately employers, employees, and other taxpayers end up paying for uncompensated care provided to the uninsured. In response to this problem, the W. K. Kellogg Foundation in 1998 launched a five-year initiative called "Community Voices," the purpose of which is

> to help ensure the survival of safety-net providers and to strengthen community support services given the unlikely prospect of achieving universal health coverage in the next five years. Building from the community level, the initiative gives the underserved a voice

[1]Hoffman and Pohl (2000).

[2]Hoffman and Schlobohm (2000).

[3]See, for example: Franks, Clancy, and Gold (1993); Weissman, Gatsonis, and Epstein (1992); and Hadley, Steinberg, and Feder (1991).

[4]Hoffman and Pohl (2000).

> to help make healthcare access and quality part of the national debate.[5]

Under Community Voices, grants were made to 13 community "learning laboratories" across the country, which were to "serve as working centers that will sort out what works from what does not in meeting the needs of those who receive inadequate or no healthcare."

One of the Community Voices grants went to Miami, Florida, where it is administered by Camillus House, a Catholic social service agency and health-care provider for the homeless. The other principal participants in Community Voices–Miami, which began in the summer of 1998, are United Way of Miami-Dade and RAND. Community Voices–Miami shares the goals of the Kellogg initiative but differs from several of the other Community Voices sites in that the primary grant recipient, Camillus House, is not housed within the major safety-net provider in the county.

RAND's task is to evaluate the Community Voices–Miami project and to provide technical assistance and policy analysis. This report derives from the analytic support role. It investigates the flow of funds through Miami-Dade County hospitals, especially with respect to unpaid charges for care (see Chapter Three). In the course of this analysis, it became clear that it was important to determine whether the flow pattern was associated with where county residents receive care, so the travel patterns of hospital patients in Miami-Dade County are also examined (see Chapter Four). The report begins with a review of the issues leading to the current interest in these topics.

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[5]http://www.wkkf.org/Initiatives/Initiative.asp?ID=1&Section=1, accessed May 17, 2001.

Chapter Two

BACKGROUND

THE PROBLEM

According to the 1999 Florida Health Insurance Study (FHIS), 24.6 percent of the nonelderly population of Miami-Dade County—nearly one-half million persons—are uninsured.[1] This is well above the national average of 16 percent,[2] ranking fourth among selected metropolitan areas (MSAs)(see Table 2.1).[3] Within Florida itself, Miami-Dade's uninsured rate is exceeded only by that of the rural midstate counties[4] (25.5 percent for those counties, taken together). Lack of health insurance is disproportionately high among ethnic minorities in Miami-Dade (see Figure 2.1) and thus also among immigrants, most of whom are ethnic minorities.

People with lower incomes in Miami-Dade are also less likely to have health insurance. The FHIS found that nearly one-third of those with incomes of less than 150 percent of the federal poverty level (FPL) lacked health insurance. In stark contrast, less than 20 percent of those with family incomes between 200 and 250 percent of the FPL lack health insurance, and less than 10 percent of those with family incomes over 250 percent of the FPL are uninsured. This supports

[1]Agency for Health Care Administration (AHCA) (2000).

[2]Moyer (1999).

[3]The MSAs were selected to be comparable to Miami—that is, they were either in Florida or had significant Hispanic populations.

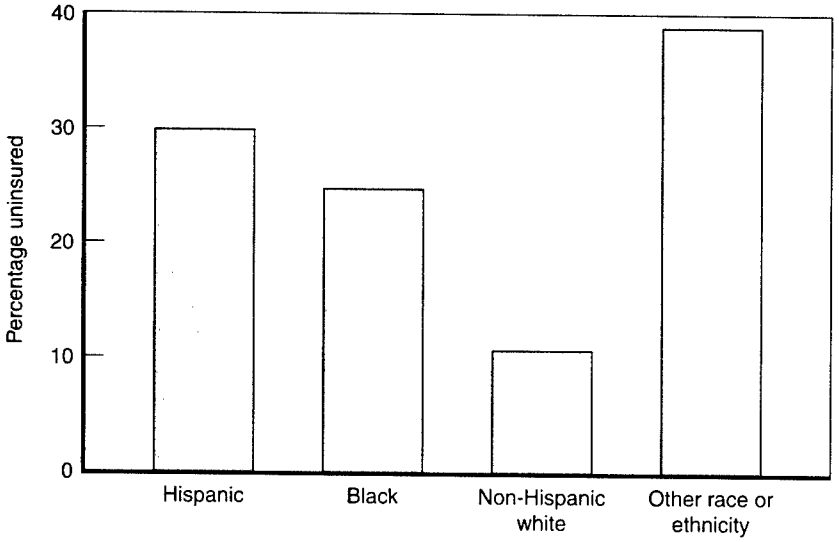
[4]De Soto, Glades, Hardee, Hendry, Highlands, Monroe, and Okeechobee Counties (Florida Health Insurance Study, AHCA, 2000).

Table 2.1

Selected MSAs with High Uninsured Rates, All Income Levels, Ages 0–64, 1997

MSA	Percent Uninsured
El Paso, TX	37
Los Angeles, CA	31
West Palm Beach, FL	29
Miami, FL	27
Tucson, AZ	26
Fort Lauderdale, FL	26
Tampa, FL	25

Source: Bureau of the Census, *Current Population Survey*, March 1998, adapted from Brown et al. (2000).

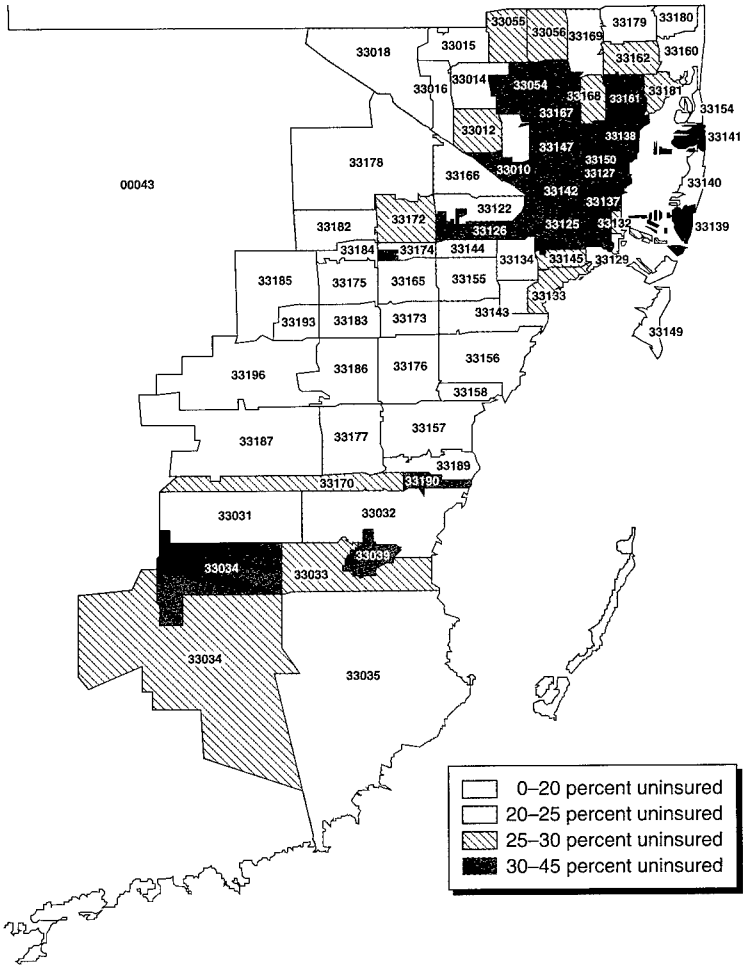


NOTE: The FHIS did not distinguish between African-Americans and Haitians.

Figure 2.1—Racial/Ethnic Minorities in Miami-Dade Are Disproportionately Uninsured

the survey's finding that the most frequently reported reason for not having health insurance is that it is too expensive and the premiums are too high.

Not surprisingly, the uninsured are distributed unevenly across Miami-Dade County (see Figure 2.2). High proportions of uninsured



SOURCE: Florida Health Insurance Study, 1999.

Figure 2.2—In Miami-Dade, the Uninsured Are Concentrated in the Central Urban Area and in the South

are concentrated in the Miami urban center and in the county's more rural south. However, most of the hospitals are located in the urban center of the county, as shown in Figure 2.3, including JMH. Thus, people living outside the urban center may need to travel when they seek hospital care.

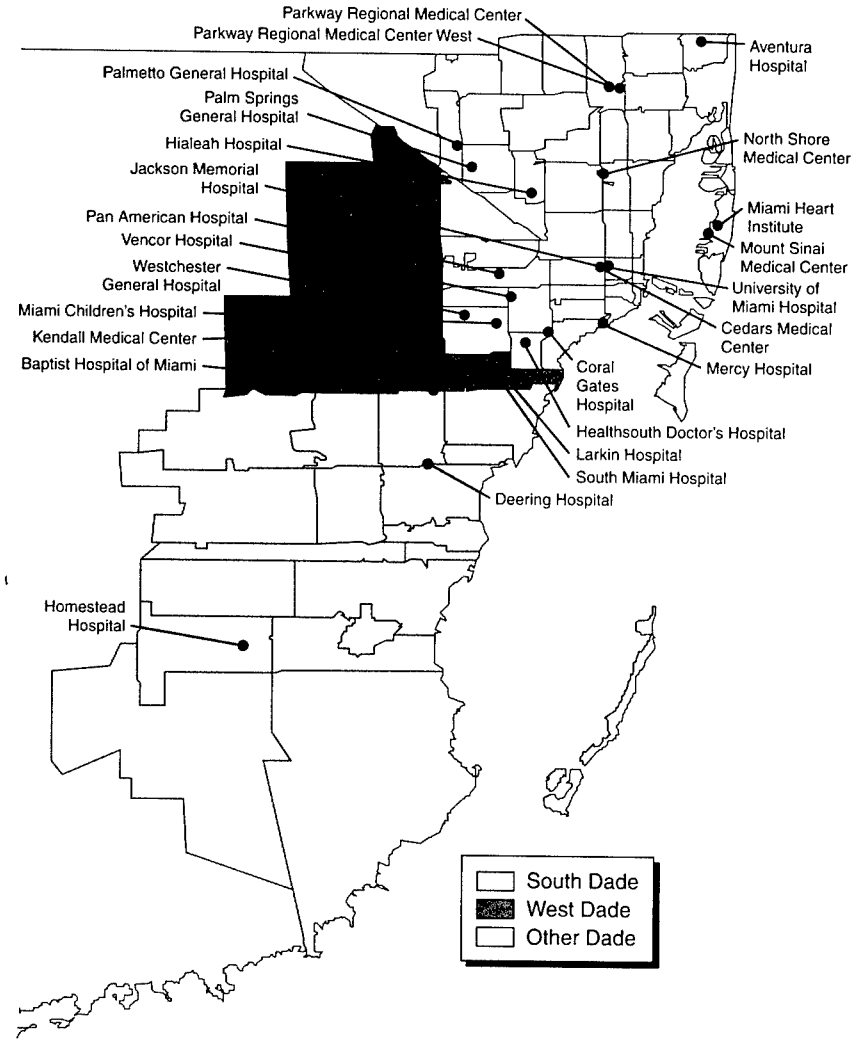


Figure 2.3—Most of the Hospitals in Miami-Dade Are Located in the Metropolitan Area of the County

RECENT ATTEMPTS TO ADDRESS THE PROBLEM

In the past ten years, a variety of local and state efforts have been made to address the problem of the uninsured in Miami-Dade County. These efforts have included planning, legislation, and litigation. The process has been contentious, with different parties motivated by different views as to which institutional arrangements best serve the uninsured.

In 1991, Florida passed legislation permitting local taxing districts to hold referenda for approval of tax levies to finance health care for the indigent.[5] In September of that year, Miami-Dade County voters approved a surtax of 0.5 percent on sales, the proceeds of which were earmarked "for the operation, maintenance and administration of Jackson Memorial Hospital to improve health care services."[6] Polls taken shortly before the vote revealed that voters of all ethnicities supported the measure, largely because they believed it would cut waiting lists for poor patients.[7] At the time the surtax was initiated, Jackson Memorial Hospital (JMH) was operating at a loss. The tax provided the funds needed to stabilize the hospital and allowed it to grow and improve. These funds helped expand hours at Jackson satellite clinics and, at least anecdotally, reduced waiting times and no-show rates.[8] Today, JMH receives over $140 million annually from the surtax[9] and is a well-respected tertiary-care hospital.[10]

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[5]Title XIV, Taxation and Finance, Chapter 212, Tax on Sales, Use and Other Transactions. For Miami-Dade County, the law assigned all surtax revenues to the sole public hospital with no requirement that the funds be dedicated to providing indigent care. The surtaxes applying to other large counties and to small counties were designated for indigent care, not assigned to the local county hospital.

[6]Language on the referendum ballot.

[7]Petchel (1991).

[8]Rogers (1993).

[9]Public Health Trust (2000).

[10]Tertiary care involves the most complex services (including open heart surgery, burn treatment, and transplantation) and is provided in inpatient hospital facilities. Primary care is oriented toward the daily, routine needs of patients (such as initial diagnosis and continuing treatment of common illnesses) and is provided in outpatient facilities. Secondary care includes "routine" hospitalization and specialized outpatient care.

JMH is ranked in the top 25 hospitals in the nation in treating eye disorders; among the top 25 hospitals in pediatrics; and among the second 25 in gynecology and in treating kidney disease, ear-nose-throat disorders, and digestive disorders (*2000 U.S.*

The surtax accomplished the goal of supplying funds to stabilize JMH and improve its health-care services. As the sole county hospital, JMH continued to provide quality care to the uninsured in Miami-Dade County. However, JMH was not the only health-care provider serving the uninsured. By 1993, other hospitals in the Miami-Dade County area that cared for the indigent had begun to voice concerns that they deserved a share of the surtax revenue.[11] These facilities argued that they were more cost-effective than JMH, and a distribution of surtax dollars to other hospitals would allow indigent patients to receive care closer to their homes.[12]

Meanwhile, controversy had also arisen over the mechanism for the planning of indigent health care. In 1991, the Miami-Dade County Commission created an Indigent Health Care Task Force to develop mechanisms to improve the delivery of health care to the uninsured. This task force included representatives from various community associations and from the Miami-Dade County Public Health Trust, a county-appointed board of community-member volunteers that had been established to oversee JMH. (The board has included as ex officio members administrators and staff from JMH as well as the University of Miami.) The task force produced an extensive plan for improving care for the uninsured and underinsured, which included 39 goals and specific recommendations for ways to achieve them.[13] Among the recommendations were the following:

- Establish an independent board to plan, control financing, and monitor the indigent-health-care system.
- Develop a system that is decentralized and reflects a community-based responsibility for indigent health care.

The County Commission did not officially accept the task force report, but action eventually was taken on the first of the two recommendations. In 1995, County Commissioner Maurice Ferré advanced

News and World Report hospital rankings, http://www.usnews.com/usnews/nycu/health, February 9, 2001, update).

[11]Nancy Ancrum, member of editing board of the *Miami Herald* (personal communication, 2001).

[12]Guber (1993).

[13]Dade County Indigent Health Care Task Force (1992).

an ordinance to create an independent authority that would submit to the County Commission unbiased recommendations on county-wide indigent-health-care planning. A semiautonomous entity was ultimately approved (Ordinance 95-71), and the Dade County Health Policy Authority was created to advise the County Commission *through* the Public Health Trust.[14] One-third of the Authority board members are also board members of the Public Health Trust (which oversees JMH), so it is not a fully independent entity. The Public Health Trust Board of Trustees passed a resolution on December 14, 2000, requesting the Health Policy Authority to simultaneously submit all reports to the Trust and to the Board of County Commissioners to "eliminate a perception that the Trust is filtering reports and not moving forward on reports submitted by the Authority."[15] However, only the Trust—not the Authority—is able to request that the reports become agenda items at Commission meetings (where they are acted upon).

The following example illustrates the restrictions and limitations of the Health Policy Authority on expeditiously and efficiently affecting health-care policy in Miami-Dade. From 1997 to 1998, the Authority, together with the Health Council of South Florida and many community partners, conducted the South Dade Community Health Initiative. This multiagency effort produced a report[16] that contained a series of recommendations to the County Commissioners (via the Public Health Trust) on ways to improve access to health care for the uninsured and underserved in South Dade, the most remote area of the county.[17] In February 1999, the Public Health Trust issued a Staff Response to the Community Health Initiative Report.[18] The Trust stated that its own planning initiatives were addressing issues similar to those raised in the report. Those initiatives included the Dade County Five-Year Plan for 1993–1998, which covered primary, secondary, and tertiary health-care services in the county. The Trust also stated that it should not bear full responsibility for addressing at

[14]Hoo-you (2000).

[15]Public Health Trust Board of Trustees Meeting minutes, December 14, 2000.

[16]South Dade Community Health Initiative Final Report, October 1998.

[17]South Dade is the southern part of Miami-Dade County, beginning at Kendall Drive (also known as SW 88th Street).

[18]Hoo-you and Lucia (1999).

a loss the unmet need for health services in all of Miami-Dade County. The Trust requested that the Health Policy Authority collect additional data to identify and quantify the voluntary contributions of not-for-profit providers toward addressing unmet needs in South Dade and to indicate how these providers could contribute toward the recommendations in the Initiative report.[19] The Trust's rationale was that these providers receive a certain financial benefit from their tax-exempt status, and therefore they should provide uncompensated care commensurate with this benefit. This rationale is consistent with the point made by some policy analysts that the level of uncompensated care provided by many institutions is not commensurate with the value of their tax exemption: Hospitals in the poorest communities tend to provide more than average uncompensated care, while those in more affluent communities often provide less than average.[20]

The South Dade Community Health Initiative Report was ultimately approved by the County Commission. In fall 2000, the Chairman of the Public Health Trust requested that the Health Policy Authority write a document, "Elaboration of Recommendations Related to the Public Health Trust as Derived from the South Dade Community Health Initiative," to enable the Trust to develop implementation plans for the recommendations. As of December 2000, the Trust had several public media initiatives under way or planned that were consistent with recommendations in the South Dade report.[21] The Trust also passed two resolutions directing staff to complete further analysis, including recommendations for implementation, related to transportation and access to primary care in South Dade.[22]

Nonetheless, the controversy surrounding the health-care surtax became even more contentious amid reports that JMH had substantial cash reserves, reported to be as much as $470 million.[23] Trust offi-

[19]Ibid.

[20]Kane and Wubbenhorst (2000).

[21]Public Health Trust Program Planning and Primary Care Committee minutes, December 22, 2000.

[22]Public Health Trust Program Planning and Primary Care Committee minutes, January 26, 2001.

[23]Balmaseda (1999).

cials contended that referring to all of these funds as reserves is misleading, since substantial amounts are legally restricted by bond issue terms, have been committed to construction programs by approved contracts, support employee-benefit programs, or have been escrowed for self-insurance liabilities based on actuary reports.[24] Moreover, it is common practice for hospitals to accumulate reserves to provide capital for expansion and renovation.[25] In 1999, Trust representatives estimated that the unrestricted funds in reserve amounted to $300 million.[26] In the midst of these community debates about JMH's cash reserves, on May 5, 2000, the Florida Legislature amended the Florida Surtax Statute to make it possible for providers other than the county hospital (JMH in Miami-Dade) to receive county funding for indigent health care.[27] However, on September 19, 2000, the Miami-Dade Board of County Commissioners declared through Ordinance 00-111 that this amendment violated Miami-Dade County's Home Rule Charter and refused to comply with it. As a result, several hospitals filed a lawsuit on February 8, 2001, to require the county to implement the surtax amendment (and thereby remit the required funds to an independent authority to fund a plan for indigent-health-care services). The lawsuit was dismissed without prejudice on July 24, 2001. The private hospitals filed an amended complaint on September 26, 2001, which has also since been dismissed.

COMMUNITY VOICES–MIAMI

The Community Voices–Miami project was thus conceived in a community that had experienced considerable debate over how to provide health care to the uninsured. The lack of major systemwide

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[24]Conchita Ruiz-Topinka, Public Health Trust, personal communication (October 12, 2001).

[25]See, for example, Lisa Gibbs, special to the *Miami Herald,* October 22, 2001.

[26]Public Health Trust Executive Committee Meeting minutes, September 27, 1999.

[27]The 1991 Florida surtax statute stated that the county must, in addition to the surtax, continue to fund the county hospital to the extent of at least 80 percent of the prior county funding (a "maintenance of effort" (MOE) requirement). The 2000 Florida surtax amendment modified the 80 percent MOE, earmarking up to 25 percent of the MOE funding for a special fund to be administered by a board independent from the board that runs the county public hospital, against which all eligible hospitals within the county could make claims (for reimbursement in proportion to the uncompensated care provided).

change motivated the project's initiators at Camillus House to establish a structure that might prove more successful at turning concepts into action. To this end, project leaders sought to establish consensus by bringing together as broad an array of community representatives and health-care providers as possible. These individuals were distributed among three standing committees with different purposes:

- The Oversight Team, composed of representatives of Camillus House, United Way, and RAND, as well as community leaders, was charged with providing administrative oversight for Community Voices.
- The Multi-Agency Consortium (MAC), composed of health-care and social-service providers, community leaders, regulatory policymakers, and other "stakeholders," was organized to create a long-term strategic plan for improving health care for the underserved and to design implementation strategies.
- The Leadership Council, composed of community leaders, was created to mobilize political and economic support for the strategic plan.

Community Voices was aware that the size, geographical layout, and economic and ethnic diversity of Miami-Dade County presented significant challenges to improving access to health care by the underserved. In addition, changes in health-care funding brought about by managed care also appeared to be eroding the ability of the county's hospitals to provide care to this group. At the second meeting of the MAC in July 1999, RAND was asked to conduct the funds-flow analysis described in the remainder of this report.

SUMMARY

- The proportion of uninsured persons in Miami-Dade County is high relative to national averages and to the proportion in other areas of Florida. Many of the uninsured live in Miami's urban center and in the southern area of the county. However, those living in the south also live far away from most hospitals.
- Local and state efforts to address the problem have achieved some success in funding care for the uninsured, primarily

through a surtax. However, the allocation of the surtax (100 percent to JMH) and the mechanism for planning indigent health care remain controversial.

- Community Voices–Miami convened an array of community representatives and health-care providers to establish a structure for improving access to care for the uninsured and asked RAND to conduct the analyses presented in this report.

Chapter Three

DISTRIBUTION OF UNCOMPENSATED CARE

The first question addressed in this analysis was, To what extent do hospitals in Miami-Dade County share the burden of providing care to the uninsured? A subsidiary question was, What sources of revenue are accessed by Miami-Dade County hospitals? These questions were raised during a discussion of hospital-specific financial information prepared by the Florida Hospital Association (FHA) for 1997. (The data are reproduced in Table A.3 in the Appendix.).[1] This information included ownership, total patient revenue, total operating costs, bad debt, charity care provided, funds received to support the provision of charity care, and the estimated costs associated with uncompensated care delivered by each hospital. The table prepared by the FHA showed that all the hospitals had some level of uncompensated care (charity care plus bad debt), but JMH was the sole hospital to receive surtax revenues that offset some of the cost of the uncompensated care it delivered.

We updated the information using data for calendar year 1999 to obtain a more current picture of the financial status of Miami-Dade County hospitals. (The updated information is presented in Table A.4 in the Appendix). The 1999 data were provided by the Florida Agency for Health Care Administration (AHCA). All hospitals in Florida annually report financial data to the state, and these data are made public in a uniform, computer-readable format, using common definitions.[2]

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[1]The table was extracted from Hoo-you and Lucia (1999).

[2]Financial information is reported according to the *State of Florida Hospital Uniform Reporting System Manual, April 9, 1992, 91-1.*

Our analysis focused on those hospitals that provided general medical services to children and adults, since their data are most relevant to the general health-care concerns of the community and the uninsured. For the Miami-Dade County area, this meant that we excluded two specialty hospitals, Bascom Palmer Eye Institute (an ophthalmic specialty institution) and South Shore Medical Center (a geriatric facility). The 24 Miami-Dade County hospitals in our sample provided more than 95 percent of the hospital care, as measured by patient charges, within the county.[3]

HOW DO HOSPITALS REPORT CARE PROVIDED TO THE UNINSURED?

The care provided to uninsured patients and to those who are underinsured is reported in two different categories, charity care and bad debt. Charity care is defined as care provided to patients who are identified as not being able to pay for the medical services they receive.[4] This determination is usually made sometime during the period in which care is provided and, as specified by state statute, requires considerable documentation. The financial reporting of charity care is closely audited to assure accuracy, since this information is used in the state's determination of disproportionate share payments.[5]

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[3]Bascom Palmer Eye Institute and South Shore Medical Center received approximately 2 percent of the total gross hospital revenues in 1999.

[4]More specifically, according to Florida Statute 409.911, charity care or uncompensated charity care is defined as "that portion of hospital charges reported to the Agency for Health Care Administration for which there is no compensation, other than restricted or unrestricted revenues provided to a hospital by local governments or tax districts regardless of the method of payment, for care provided to patients whose family income for the 12 months preceding the determination is less than or equal to 200 percent of the federal poverty level, unless the amount of the hospital charges due from the patients exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for patients whose income exceeds four times the federal poverty level for a family of four be considered charity" (State of Florida Statutes, Title XXX [Social Welfare], Chapter 409 [Social and Economic Assistance], 2001).

[5]The federal regulations for the Medicaid program require states to take into account the special payment needs of hospitals serving low-income populations. In particular, hospitals that treat a high proportion of uninsured or Medicaid-insured patients receive adjusted payment rates through the Disproportionate Share Payment (DSP) program.

Bad debt, in contrast, is usually identified after care has been provided. Bad debt includes amounts not recovered from patients who are identified as "self-pay," and amounts that are not fully recovered from insured patients. A recent study that matched hospital bills with state tax records in Massachusetts showed that many patients whose hospital expenses were determined to be bad debt could actually have qualified for charity care.[6] The occurrence of this misclassification in a state that provides fiscal relief to hospitals for charity care is significant.

The conceptual distinction between charity care and bad debt rests on the presumption of payment in situations that result in bad debt, whereas there is no such presumption for charity care. In practice, however, the distinction between the two can often be blurred. For this reason, studies that examine the financial impact on hospitals of providing care to persons without health insurance combine the costs of charity care and bad debt into "uncompensated care."[7] Nonetheless, it is important to note that charity care and bad debt are not the same, and caution should be used when combining the two in analyses.

Table 3.1 broadly shows how the burden of charity care and bad debt are distributed among the hospitals in Miami-Dade County for 1999. Of the 24 hospitals included in our analysis, more than half (15) are for-profit institutions owned by investors. Nine hospitals are not-for-profit institutions, and one of these, JMH, is a public hospital.

Total patient charges reported for Miami-Dade hospitals included in the analysis amounted to just under $7.3 billion for 1999. To convert the charge data to cost data, we used a hospital-specific cost-to-charge ratio,[8] i.e., the ratio of total operating expenses to gross patient charges. Table 3.1 shows the average cost-to-charge ratios for

[6]Weissman, Dryfoos, and London (1999); and Weissman, Van Deusen Lukas, and Epstein (1992).

[7]For example, see Mann, Melnick, Bamezai, and Zwanziger (1997); and Thorpe, Florence, and Seiber (2000).

[8]We calculated the cost-to-charge ratios using the data reported to the Florida State Agency for Health Care Administration. We compared these to the cost-to-charge ratios calculated from the Medicare Cost Reports for FY 1999. There were few differences, most of which were probably due to timing. The Florida financial data are for the calendar year, and the Medicare data are for the fiscal year.

each category of hospital. The mark-up, which is equal to the reciprocal of the cost-to-charge ratio minus 1, is 1.44, or 144 percent, for the not-for-profits; 223 percent for the investor-owned hospitals; and 101 percent for JMH. Thus, as would be expected, prices charged at for-profit hospitals (i.e., investor-owned hospitals) exceed costs by a greater amount than do prices charged at not-for-profit institutions.

We looked at the percentage of operating costs for charity care and bad debt both separately and together to understand the burden that uncompensated care imposes on hospitals (see Table 3.2). The levels of bad debt acquired and charity care provided vary by hospital type—for-profit, not-for-profit, and county. The overall cost of bad debt, i.e., bad debt multiplied by the cost-to-charge ratio, is 3.2 percent of operating expenses: 4.3 percent for for-profit hospitals, 3.0 percent for not-for-profit hospitals, and 1.9 percent for JMH. Similarly, the burden of charity care varies by hospital type. The costs of charity care represent 6.8 percent of operating expenses overall, 1.1 percent for for-profit hospitals, and 1.4 percent for not-for-profit hospitals.

Table 3.1

Summary of Florida Hospital Financial Data, 1999

Item	Total Miami-Dade Hospitals (n = 24)	Investor-Owned Hospitals (n = 15)[a]	Not-for-Profit Hospitals (n = 8)[b]	Jackson Memorial Hospital[c]
Total patient charges ($)	7,303,531,061	3,423,216,722	2,447,078,001	1,433,236,338
Total operating expenses ($)	2,795,759,463	1,069,872,549	1,011,927,609	713,959,305
Average cost/charge	0.38	0.31	0.41	0.50
Gross bad debt ($)				
Sum	249,615,860	147,236,476	75,324,499	27,054,885
Average	10,400,661	9,815,765	9,415,562	
Gross charity ($)				
Sum	404,403,801	40,172,155	35,915,033	328,316,613
Average	16,850,158	2,678,144	4,489,379	
Cost of bad debt ($)				
Sum	90,009,972	46,316,431	30,216,289	13,477,252
Average	3,750,415	3,087,762	3,777,036	

Table 3.1 (continued)

Item	Total Miami-Dade Hospitals (n = 24)	Investor-Owned Hospitals (n = 15)[a]	Not-for-Profit Hospitals (n = 8)[b]	Jackson Memorial[c]
Cost of charity care ($)				
Sum	190,956,166	12,555,175	14,851,759	163,549,231
Average	7,956,507	837,012	1,856,470	
Surtax revenues				141,989,707[d]
Cost of charity care as % of operating expenses	6.8	1.1	1.4	23.0 3.0[e] 13.0[f]
Cost of bad debt as % of operating expenses	3.2	4.3	3.0	1.9
Total uncompensated care as a proportion of costs	10.0	5.5	4.4	24.8 4.9[e] 14.9[f]

Notes: Data for Coral Gables and Parkway Regional Medical Center were incomplete. These incomplete data were adjusted to estimate the 1999 data, using the Miami-Dade County percentage changes calculated from the complete data reported for 1998 to 1999. The estimated cost of uncompensated care = cost/charge ratio (bad debt plus charity care) –(restricted funds for charity + surtax revenue).

[a]Aventura Hospital and Medical Center, Cedars Medical Center, Coral Gables Hospital, Deering Hospital, Healthsouth Doctor's Hospital, Hialeah Hospital, Kendall Medical Center, Larkin Community Hospital, Miami Heart Institute/Mount Sinai, North Shore Medical Center, Palm Springs General Hospital, Palmetto General Hospital, Parkway Regional Medical Center, Vencor Hospital-Coral Gables, and Westchester General Hospital were identified as investor-owned during 1998 and 1999.

[b]Baptist Hospital of Miami, Homestead Hospital, Mercy Hospital, Miami Children's Hospital, Mount Sinai Medical Center, Pan American Hospital, South Miami Hospital, and University of Miami Hospital and Clinics were identified as not-for-profit during 1998 and 1999.

[c]JMH is a tertiary, academic teaching hospital whose specialized services result in higher costs than those at community hospitals.

[d]JMH is the only hospital that receives restricted and unrestricted funds (surtax revenue).

[e]If all the surtax funds are used to offset charity care.

[f]If one-half of the surtax funds are used to offset charity care.

Table 3.2

Uncompensated-Care (Charity Care plus Bad Debt) Costs (percentage of operating expenses)

Type of Hospital	Miami-Dade County, 1999	National Benchmarks, 1995[a]
Not-for-profit	4.6	4.6
For-profit	5.4	4.1
Major public teaching[b]	24.8	17.6

[a]Data from Prospective Payment Assessment Commission (1996).

[b]Jackson Memorial Hospital is the major public teaching hospital in Miami-Dade County.

Determining the costs of charity care at JMH is not as straightforward as it is for other hospitals. Jackson receives county revenues as a result of the surtax enacted in 1992. This amounted to approximately $142 million in 1999.[9] If none of these revenues offsets the costs of charity care, that care accounts for 23 percent of operating expenses at JMH. However, if all the surtax is used to fund indigent care, charity care represents just 3 percent of operating costs. If the surtax funds are assumed to support a combination of indigent care and other purposes, half of the surtax revenues might be considered to offset charity care, so 13 percent of operating expenses would be attributable to charity care.[10]

Adjusted costs for uncompensated care for Miami-Dade not-for-profit hospitals as a group are 4.4 percent of total operating costs; those for investor-owned hospitals are 5.5 percent. The difference between the not-for-profits and the investor-owned hospitals lies primarily in the higher levels of bad debt incurred by the latter. The adjusted costs for uncompensated care at JMH vary from 24.8 percent of operating costs when none of the surtax revenues is consid-

[9]As discussed in Chapter Two, the ballot language that created the surtax stated that the funds were to be used "for the operation, maintenance and administration of Jackson Memorial Hospital to improve health care services."

[10]According to the Public Health Trust budget for 1999, over half the surtax funds—approximately $70 million—are mandated by the county to support various programs such as primary-care-center support, county Medicaid liability, and nursing homes.

ered to 4.9 or 14.9 percent when all or half of the surtax revenues are assumed to offset uncompensated-care costs.

A comparison of these Miami-Dade County figures with national benchmarks shows that the level of uncompensated care in Miami-Dade hospitals is not much different from that experienced elsewhere. The levels at for-profit hospitals in Miami-Dade, however, appear to be somewhat higher than the national experience. Moreover, there are proportionately more for-profit hospitals in Miami-Dade County than there are nationally.[11] Jackson Memorial Hospital appears to face a level of burden slightly higher than that of major public teaching hospitals nationally.

UNCOMPENSATED CARE PROVIDED BY HOSPITALS IN THE COUNTY

Hospitals across the county share the burden of uncompensated care, as shown in Figure 3.1, which shows those hospitals that reported complete financial data.[12] There are three separate bars for Jackson Memorial Hospital. The first, labeled (A), represents the case where none of the surtax revenues are used to offset charity care costs. The second, labeled (B), assumes the use of one-half of the surtax revenues to offset charity-care costs. The third, labeled (C), assumes the use of 100 percent of the surtax revenues to offset charity-care costs.

If none of the surtax revenues offsets charity care at JMH, it and Homestead Hospital provide the highest proportion of charity care, as measured by the proportion of operating expenses. However, if one-half of the surtax revenues is used to offset charity care at JMH, other hospitals, especially Homestead Hospital, have a greater uncompensated-care burden. If all the surtax funds are used to offset charity care, the proportion of operating costs that charity care alone represents falls below that of Homestead Hospital.

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[11]In 1999, 6.6 percent of all hospitals in the United States were for-profit hospitals (data from American Hospital Association, AHA).

[12]In the 1999 hospital financial data provided by the Florida Agency for Health Care Administration, Larkin Hospital reported a positive offset in bad debt; the data from Coral Gables and Parkway were not complete.

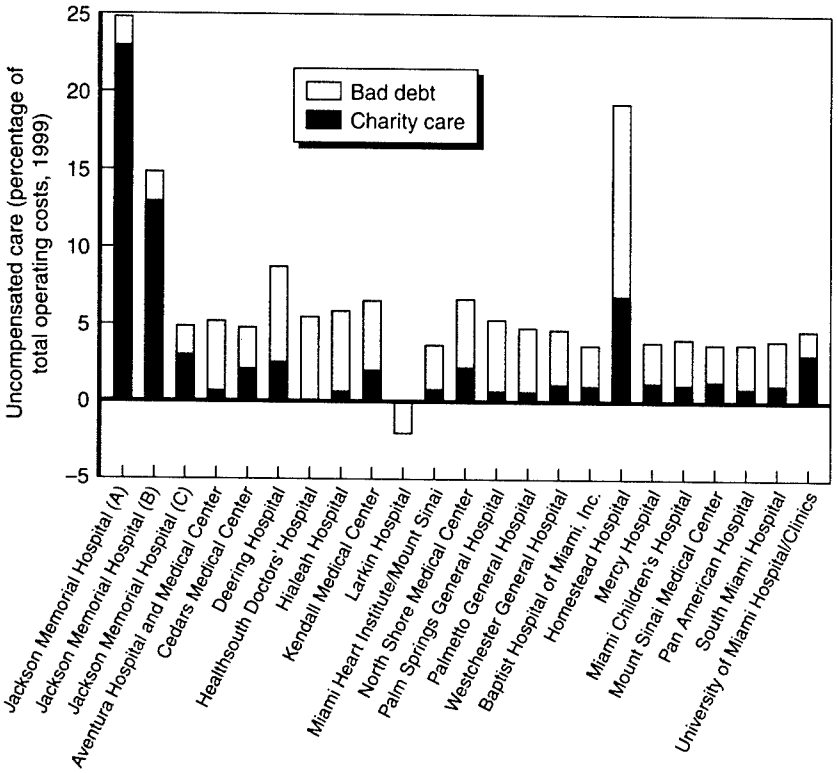

Figure 3.1—Uncompensated Care Is a Substantial Percentage of Operating Expenses at Several Miami-Dade County Hospitals

Figure 3.2 presents the same data in dollar terms. As can be seen, JMH bears by far the highest cost of uncompensated care among Miami-Dade County hospitals; it is also the sole public hospital and the largest hospital in the county.

The 50 percent offset for JMH shown in Figure 3.1 derives from an FHA 1997 estimate of the costs of uncompensated care in Miami-Dade County. The formula used by the FHA is given in the note to Table A.3 in the Appendix. According to the FHA, the 50 percent reduction was derived historically from the assumption that half the surtax revenue would be used directly by the hospital, while the rest would be used for programs that benefited the community at large.

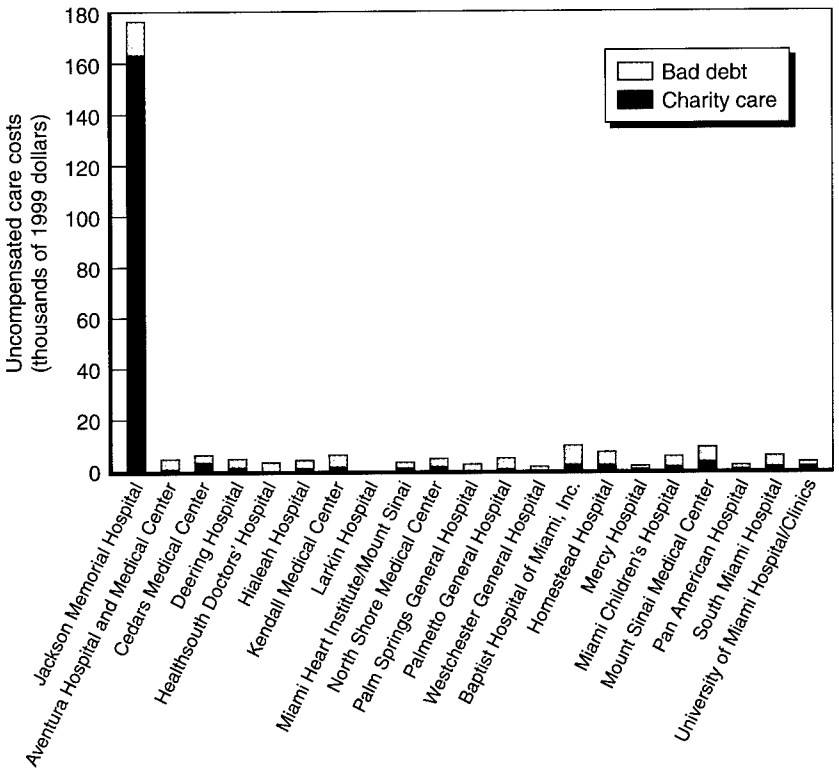

Figure 3.2—JMH Has the Highest Costs of Uncompensated Care, in Absolute Dollar Terms, of All Miami-Dade County Hospitals

However, the FHA elaborated that the assumption had no empirical basis, and in fact, they had decided to stop using it in reporting the costs of uncompensated care. This change in reporting procedure would mean that JMH did not experience a loss due to uncompensated care in 1999, but rather received $4.8 million above its costs.[13] Irrespective of the intended purpose of the surtax funds—to support specialized and regionalized services at JMH or to provide funds for

[13]With the change in reporting procedure, the cost of uncompensated care at JMH in 1997 would have been not $74.8 million, but negative $4 million; that is, if the entire surtax were applied to JMH's share of the uncompensated care, the hospital would have realized a profit of $4 million.

indigent care—the surtax represents a major source of revenue for JMH. The $142 million in surtax funds provided to JMH for 1999 covered nearly 20 percent of the hospital's operating expenses.

Figure 3.2 clearly shows that bad debt is a major contributor to the cost of overall uncompensated care for all hospitals, with the stark exception of JMH, where less than 2 percent of operating costs were attributable to bad debt. The administrators at JMH assert that they have made better management decisions, including negotiating better contracts (i.e., more favorable discount rates) with third-party payers. This issue is explored below.

EFFECT OF DISCOUNTING ON HOSPITAL REVENUE

According to Table 3.1, the total cost of care provided by Miami-Dade hospitals in 1999 was approximately $2.8 billion. The difference between total patient charges and operating costs was $4.5 billion. This would suggest that Miami-Dade County hospitals made profits in 1999. However, this "profit" is illusory. It must be reduced not only by the costs of uncompensated care, but also by the discounts the hospitals provide on most of their charges. This is most easily understood in the context of the full spectrum of hospital revenue sources.

The hospitals in Miami-Dade County provide care to a diverse population that, in turn, generates a variety of revenue sources. Figure 3.3 presents an overview of sources of payment for charges made by all hospitals in Miami-Dade County, based on the hospital financial data from AHCA. Coral Gables Hospital and Parkway Regional Medical Center have been excluded from this analysis because their data were incomplete.[14]

Like hospitals nationwide, Miami-Dade hospitals depend heavily on the traditional payers, Medicare and Medicaid. In 1999, 29 percent of Miami-Dade hospital charges were for care provided to conventional-Medicare recipients and 13 percent were for conventional-Medicaid recipients. Medicare and Medicaid managed-care plans

[14]The exclusion of these hospitals did not qualitatively affect the distribution of revenues by payer.

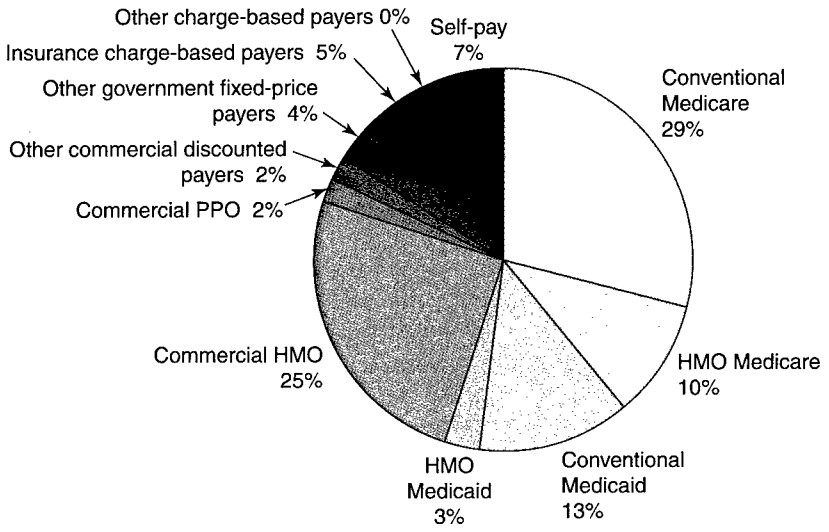

Figure 3.3—Traditional Payers Such as Medicare and Medicaid Are Still Prominent in the Miami-Dade Health-Care Market

(HMOs) paid for 10 percent and 3 percent of hospital charges, respectively. Commercial HMOs and Preferred Provider Organizations (PPOs) paid for 25 percent and 2 percent of hospital charges, respectively. Other discounted and fixed-price payers represented 6 percent in the aggregate. Less than 5 percent of hospital charges were billed to charge-based payers. Self-pay patients accrued 7 percent of hospital charges overall.

Thus, while managed care came relatively late to south Florida, it now is a significant player in the health-care market. Negotiated-price plans, such as HMOs and PPOs, use competition to drive down the amount they pay hospitals. This in turn reduces hospitals' margins and their ability to expand or improve services. Moreover, the reduced realized revenues mean that any level of uncompensated care provided cuts deeply into hospitals' profitability and financial health.

Discounting, that is, the practice of offering third-party payers[15] a rate for goods and services that is lower than the price tag or *charge,* encourages third-party-payer beneficiaries to use the hospital offering the discount. Thus, while discounting reduces per-patient income, it presumably increases the number of patients who use the hospital; total income will be augmented if the percentage increase in patients exceeds the discount percentage.

The financial data reported to the AHCA show that among the 22 hospitals with complete data in Miami-Dade County, conventional-Medicare recipients receive discount rates ranging from 35 percent to 75 percent, and Medicare HMOs receive discount rates ranging from 26 percent to 92 percent. Overall, the average discount rate is 45 percent.[16] Because of the high proportion of patient charges subject to discounting, only a small number of patients have their hospital charges fully reimbursed. The key for most hospitals, then, is to enter into arrangements with health-care plans that will ensure a constant pool of users, while keeping discounted charges higher than operating costs. In a competitive hospital market, there is considerable tension between these two objectives.

TAX-EXEMPT STATUS AND THE PROVISION OF INDIGENT CARE

When asked for their position on the extent to which surtax revenues appeared to offset their costs of uncompensated care, the JMH administrators said that the tax-exempt status granted not-for-profit hospitals implied a quid pro quo: Nonprofit hospitals would provide services to the community (for example, uncompensated care) in exchange for a reduction in or avoidance of taxes. Estimating the theoretical cost savings from the tax-exempt status afforded Miami-Dade

[15]Third-party payers are payers who are neither the giver nor the recipient of care; these include the government and private-sector insurers—all contributors in Figure 3.1 except for self-pay.

[16]The discount rate is calculated as total patient charges minus total deductions from charges, divided by total patient charges.

County not-for-profit hospitals and making comparisons to the amount of uncompensated care provided by these hospitals was beyond the scope of this analysis. And we noted that investor-owned hospitals receive no tax exemption, yet some provide charity care.[17]

Tax exemption is conferred on not-for-profit hospitals and other nonprofit organizations because such organizations provide benefits to the community in exchange for not paying taxes.[18] These benefits, which have recently come to be known as *community benefits,* are public goods provided to persons without expectation of payment and may include such services as indigent-care provision or free cancer screenings. Community benefits also benefit the community as a whole: Providing health care, regardless of one's ability to pay, makes for healthier communities.

Florida does not have a community benefits statute. Indeed, few states have explicit regulations that provide guidance to not-for-profit hospitals on the level of community benefits they should provide. New Hampshire defines community benefits to include charity care; financial or in-kind support of public-health programs; allocation or donation of funds, property, and services to contribute to community health needs or promote a healthier community; and support of medical research and education.[19] The Michigan Health and Hospital Association expanded the definition of community benefits to include any uncompensated care (charity care or bad debt) plus the unreimbursed costs of Medicaid and Medicare.[20] Thus, while there appears to be support for a quid pro quo with respect to the tax-exempt status of not-for-profit hospitals, there is no consensus as to how this should be defined.

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[17]All hospitals reported some level of uncompensated care. For two investor-owned hospitals that do not report any charity care, Healthsouth Doctors Hospital and Larkin Hospital, the uncompensated care is composed solely of bad debt.

[18]See Reinhardt (2000); and Kane and Wubbenhorst (2000).

[19]Statement of Community Benefits Statues, RSA 7:32-e, New Hampshire, Department of Justice (http://webster.state.nh.us/nhodoj/CHARITABLE/commbenefits. htp).

[20]MHA Community Benefits Measurement Project, Michigan Health and Hospital Association (http://www.mha.org/commbenreport.asp).

SUMMARY

- Hospitals in Miami-Dade County provided approximately $650 million gross charges, or $281 million in costs of uncompensated care, in 1999. The surtax raised approximately $140 million. Clearly, surtax dollars are insufficient to finance uncompensated hospital care.
- All hospitals in the county provided some uncompensated care, although the absolute amounts varied, as did the relative amounts (as percentages of total operating costs).
- JMH and Homestead Hospital had the highest uncompensated-care burdens in the county.
- Some consider uncompensated care part of the community benefits that not-for-profit hospitals should provide, but neither Miami-Dade County nor Florida has an explicit policy on how much uncompensated care should be provided.

Chapter Four

GEOGRAPHIC ACCESS TO CARE

To assess whether the organization and financing of indigent care in Miami-Dade was associated with the locations at which uninsured patients received treatment, we performed an analysis of access to hospital care based on how far patients traveled to get such care. Our objective was to determine whether or not uninsured patients had geographic access to hospital care similar to that of their insured neighbors.

Geographic access is only one dimension of access to care, but it is a potentially important one. Patients who travel great distances may not receive care in a timely manner. Moreover, those who are hospitalized far from their homes may experience transportation difficulties and reduced family support. Indeed, research has shown that patients generally tend to be admitted to hospitals that are close to their homes.[1] Of course, patients go to particular hospitals for a number of different reasons—for example, they may go to a hospital recommended by friends and family or to a hospital where their doctor has admitting privileges.[2] Travel patterns reflect individual preferences and therefore, to some degree, personal choice. But our principal concern is the issue of whether differential geographic access reflects disparities in the health-care system. This focus requires that other factors be netted out in our comparison of insured and uninsured patients. If the uninsured had unlimited access to care,

[1]Adams, Houchens, Wright, and Robbins, (1991); Garnick, Lichtenberg, Phibbs, et al. (1989); Luft, Garnick, Mark, et al. (1990); and Phibbs, Mark, Luft, et al. (1993).

[2]Burns and Wholey (1992).

their travel patterns for receiving hospital care should resemble those of patients with health insurance. This analysis may thus help in evaluating the effects of proposed policy changes on hospital funding and access to care for the uninsured.

ANALYZING PATIENT TRAVEL PATTERNS

Our analysis of patient travel patterns used patient-level hospital discharge data for 1999 provided by AHCA. All Florida hospitals annually report information on the patients treated at their facility, including patient-specific information such as age, gender, expected source of payment (payer), zip code of residence, type of admission, discharge diagnoses, and length of stay.[3]

This analysis considers Miami-Dade County residents who received care in Miami-Dade County hospitals. We excluded patients who received care more than 75 miles from their homes, because these patients generally have unusual reasons for their hospital choice, that is, they were admitted for an emergency while they were away from home or they had very strong hospital preferences that went beyond the typical reasons.

Patients without valid residential zip codes were also excluded, because our analysis required residential zip code information. We excluded several categories of patients that might have confounded the analysis. These categories included patients over the age of 65 and those for whom hospital care was paid by Medicare, Medicaid, HMOs, worker's compensation, or the Veterans' Administration. Since both the hospital and the patient know that payment for care is virtually assured in these cases, we expected that travel patterns would not be influenced by the same factors that divide insured from uninsured patients. We also excluded hospitalizations associated with normal childbirth (those with a principal-diagnosis code of 650) because Medicaid routinely covers deliveries for women who do not have health insurance. Finally, we excluded those admissions that were transferred from another hospital, because these patients usu-

[3]For our analyses, these publicly available data were de-identified and did not include full patient residential address, making it impossible to identify individual patients.

ally have severe conditions that require specialized services that may not be available at all hospitals.

Our travel analysis used the proximity rank of the hospital to which the patient was admitted as the metric of geographic access. That is, we determined how many hospitals were closer to the patient's home than the one to which he or she was admitted. So we say that a person skipped[4] no hospitals if he or she was admitted to the closest one, skipped one if admitted to the second-closest, and so on. We did not seek fine differences in distances traveled to receive care. Rather, we compared the influence of insurance on the likelihood of going to a hospital close to home (skipping no more than one hospital) or far away (skipping nine or more hospitals).

Comparing numbers of hospitals skipped is preferable to using a simple distance measure because it corrects for differences in local hospital density. In outlying areas, distances traveled might be greater simply because hospitals are farther apart. The implications of hospital density for access are of some interest, but we focused on factors suggestive of hospital preferences for some patients and patient preferences for some hospitals. (In the following discussion we sometimes speak of farther travel as shorthand for more hospitals skipped.)

To further control for characteristics of the underserved that might affect hospital choice, we compared the travel behavior of patients who live in similar neighborhoods, as defined by residential zip code. Conducting the analysis at the zip-code level provides some statistical control for unobserved characteristics that might affect hospital choice. For example, neighbors may share information about hospital facilities—e.g., quality of care, amenities, friendliness of staff—that affect hospital choice.

To determine the hospital proximity rankings, we first calculated the distances between the patient's zip code of residence and the zip codes of all Miami-Dade hospitals.[5] The actual distance measured is

[4]"Skipping" is not meant to imply that a patient necessarily elected voluntarily to bypass hospitals closer to home.

[5]Hospital zip codes were obtained from a variety of sources, including AHA directories, and were merged with the Florida hospital data. This required a manual

the distance from the geographic center of one zip code to that of another. This measure would be imperfect if we were to analyze distance traveled, because patient residences and hospitals are located anywhere within a zip code. However, it is suitable for ranking hospital proximity and could be calculated easily with available data.[6] Once the inter–zip-code distances were calculated, we ordered the hospitals from closest to farthest from the patient's residential zip code. The ranking of the discharge hospital reflects the relative proximity of the hospital to the patient's home.[7]

Although we analyzed by zip code of residence, we do not present results that way, because we do not need such a fine scale to identify policy-relevant differences in the influence of insurance on travel patterns. Instead, we have averaged across broad aggregations of zip codes that have similar densities of health-care services and population. Hospitals in Miami-Dade County are concentrated in the urban center, close to the concentration of the population. There are fewer hospitals outside this area.

This analysis is primarily concerned with two regions of Miami-Dade County: South Dade and western Dade (see Figure 4.1). Both areas have been the focus of previous studies by Miami-Dade health planners,[8] because, as shown in Figure 2.2, there are relatively fewer hospitals in these areas, and many persons lacking health insurance live in South Dade. We do not look separately at the northern part of the county that borders Broward County because Broward County hospitals are closer than Miami-Dade hospitals for many of the residents in this area. Analyzing their travel patterns would not reveal information about intra–Miami-Dade travel for hospital care. Nor do

match of hospitals by hospital name, because the AHA and AHCA Florida data use different hospital identifiers. All Florida hospitals were matched in preparation for intrastate analyses.

[6]Because the inter–zip-code distances are not perfect measures of the distance a given patient traveled to a given hospital, we do not use average distance traveled as a measure of access.

[7]Because our distance measure is crude, there were ties in the rankings of hospitals. In cases of ties, we used the lowest ranking. For example, if two hospitals were close to a patient's zip code, they were both ranked 1; the third hospital would then be ranked 3. Our analysis focuses on the extremes of the rankings.

[8]We use the same zip code aggregates for western and South Dade as used in previous studies of these areas.

we look separately at the urban center. Although many uninsured live in this area, the high population as well as hospital density means that patients need not "travel" for hospital care.

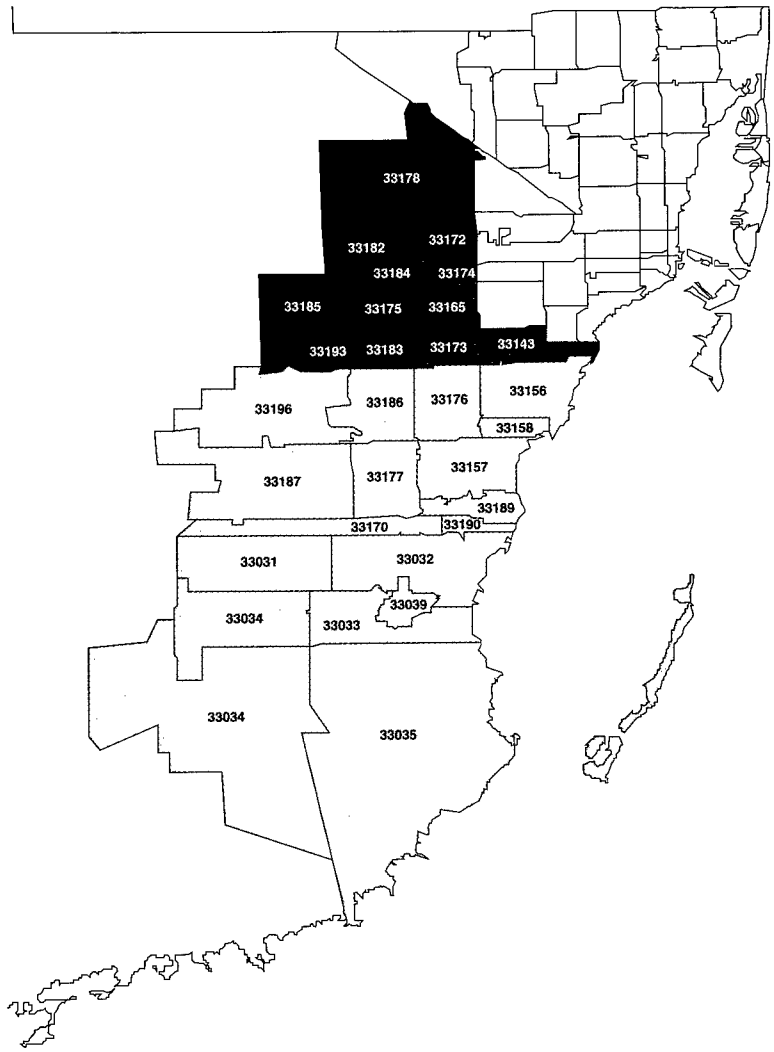

Figure 4.1—Zip-Code Map of Southern (Lightly Shaded) and Western (Darker) Areas of Miami-Dade County

Overall, residents in the western and southern areas accounted for about 14 percent of all hospitalizations of uninsured persons in the county. The centralized approach taken by the Public Health Trust is also likely to have the greatest impact on those living farther away from JMH, which is located in the urban center. Thus, we were concerned with whether the travel patterns for residents of southern and western Miami-Dade County differed by payer type from those seen for the county as a whole. The distance to JMH would be picked up in our average proximity measurements, and we could test for percentages going to that hospital in particular by payer type.

To analyze the data, we identified three health-insurance payer types: commercial insurance, Medicaid, and no insurance. If health insurance does not affect patients' travel patterns, there should be no difference among the groups. In our comparisons, we implicitly used the travel patterns of commercially insured patients as the benchmark. While many commercial insurance plans have restrictions regarding service providers, commercially insured patients can generally receive coverage in facilities of their choice. Thus, we assume that the travel patterns of commercially insured patients reflect an optimization across available hospital facilities and patient choice. If there are differences in travel patterns, they can be attributed to health-insurance type. We were also interested in determining whether the influence of insurance type on access varied between adult and pediatric patients or between emergency admissions and urgent or elective admissions.

We separated emergency admissions from other (urgent and elective) admissions because even the most restrictive health-care plans permit out-of-plan use for emergency care. We would expect (or at least hope) that under emergency conditions, insurance type would have little effect on choice of hospital. It could be argued that, for those reasons, we should have classified urgent admissions with emergency admissions because they might be equally time-sensitive. But are they? To answer this question, we examined the top ten ICD 9[9] admission diagnoses for emergent, urgent, and elective admissions for 1997 (see Tables A.1 and A.2 in the Appendix). We found that eight of the top ten emergency admission conditions for adults

[9]International Classification of Diseases, 9th revision.

are not included in the list of urgent or elective admission conditions. Emergency conditions tend to require immediate admission, because they are potentially life-threatening. The two emergency admission conditions that are also urgent—paranoid schizophrenia and coronary atherosclerosis—can present with severity ranging from the need for immediate admission to the possibility of elective admission. The conditions listed as most commonly resulting in urgent or elective admission are less time-sensitive than those classified as emergent.

For pediatric patients, the distinction between the three types of admissions is less clear. Six of the top ten emergency conditions are also listed among the most frequent conditions for urgent or elective admission (Table A.2). Some of the similarity in admitting diagnoses among emergent, urgent, and elective may be due to the greater immediacy of medical care for children than for adults. However, the conditions listed in Table A.2 reaffirm the conventional wisdom that children are hospitalized for pneumonia, bronchitis, asthma, and dehydration. Like coronary atherosclerosis and paranoid schizophrenia in adults, each of these pediatric conditions has a range of severity that is reflected in its prevalence as an admitting condition for all three admission categories. If we had found no differences between insurance categories in travel patterns of children, we might have attributed that to our decision not to combine elective and urgent admissions. However, as we did find differences, we are satisfied with the current classification.

Because no individual-specific identifying information is included in the Florida hospital discharge data, we cannot follow individual patients over time and thus cannot identify the care-seeking behavior of individuals. However, data from the 1996 National Health Interview Survey indicate that approximately 22 percent of hospitalizations in the southern United States reflect multiple admissions for a given individual. Some of our discharge data must thus reflect repetitive admission preferences of the same patients. Ideally, we would like to avoid repetitive admissions. It might be that patients who are repeatedly hospitalized are in worse health and allow insurance to influence their hospital choices in different ways than do patients hospitalized only once. Because of data limitations, we cannot make adjustments for multiple admissions.

Travel Patterns for Adult Patients

Table 4.1 presents summary findings for adult-patient travel patterns. As shown in the table, 38.45 percent of the 57,586 commercially insured patients, 43.57 percent of the 29,715 Medicaid patients, and 41.97 percent of the 22,208 uninsured patients were discharged from the closest or second-closest hospital to their homes. An *a* in the "Significant Difference" columns indicates that the difference between the commercial and Medicaid percentages is statistically significant (at the 0.001 level), as are the other two differences, as coded. (It is not necessary to consult the letter codes, as they can be read off the rows in the table in which the letters are placed: *a*, for example, always shows up in both the Commercial and Medicaid rows

Table 4.1

Adult Travel Patterns Across Admission Categories, Miami-Dade County, 1999

Insurance Type	Total Patients	% of Patients Discharged at Proximity 1 and 2 Hospitals	Significant Difference[a]	% of Patients Discharged at Proximity 10+ Hospitals	Significant Difference[a]
		All Miami-Dade County			
Commercial	57,586	38.45	a*** b***	26.29	b***
Medicaid	29,715	43.57	a*** c***	26.04	c***
Uninsured	22,208	41.97	b*** c***	28.15	b*** c***
Total	109,509				
		South Dade County			
Commercial	12,518	50.99	a***	13.95	a*** b***
Medicaid	4,519	58.42	a*** c***	24.92	a*** c***
Uninsured	3,173	50.05	c***	35.01	b*** c***
Total	20,210				
		West Dade County			
Commercial	10,553	36.76	a*** b***	28.48	a*** b***
Medicaid	2,531	31.09	a*** c***	43.58	a*** c***
Uninsured	2,320	29.01	b*** c***	54.27	b*** c***
Total	15,404				

Significance tests: a = Commercial/Medicaid comparison; b = Commercial/uninsured comparison; c = Medicaid/uninsured comparison; *p<= 0.05 ** p<= 0.01 *** p<=0.001.

or not at all.) In the case of the percentages discharged from faraway hospitals (proximity ranking 10+), the difference between the commercial and uninsured percentages is statistically significant, as is that between the Medicaid and uninsured. But the difference between the commercial and Medicaid percentages is not statistically significant (there is no common code letter between those two rows).

For completeness, we display the results for the county as a whole. While most of the differences between the whole-county percentages are statistically significant, the absolute differences are small and thus not very meaningful from a policy perspective. The largest is the 5.1-percentage-point difference between commercially insured and Medicaid patients, which indicates that Medicaid patients are somewhat more likely than the commercially insured to go to hospitals close to their homes. This may reflect the concentration of Medicaid patients in the inner city, close to JMH and other urban hospitals. What we are primarily interested in, however, is geographic access of the dispersed poor, and for that we must look at the data sorted by geographic region. First, however, we note that for the county as a whole, nearly 40 percent of adult patients receive treatment in the hospital closest or second-closest to their homes. This is consistent with prior research showing that many people are hospitalized close to their homes.

Our analysis reveals some interesting patterns: Medicaid patients living in South Dade are the most likely to be hospitalized close to home. In the western part of the county, however, commercially insured patients are the most likely to be hospitalized near their homes. One reason for the difference may be that the hospitals in South Dade are all not-for-profit, which is not the case in western Dade.

In the south and the west, there is a gradient in the likelihood that nine or more hospitals will be skipped, with commercially insured patients less likely than Medicaid patients to skip nine or more, and Medicaid patients less likely to do so than the uninsured. Across this gradient, uninsured patients are more than two times more likely to skip nine or more hospitals as commercially insured patients living in the same area (see Figure 4.2).

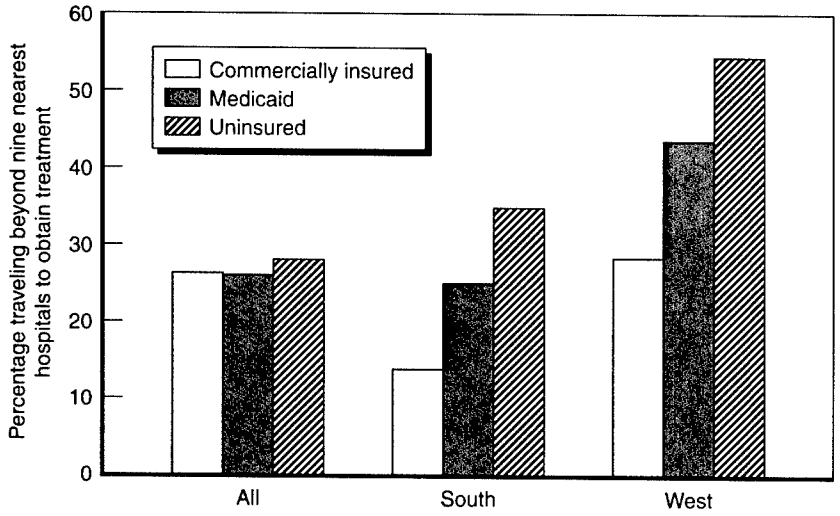

Figure 4.2—In South and West Miami-Dade County, Uninsured Patients Travel Farthest to Hospitals, and the Commercially Insured Travel Least

Let us now turn to differences across types of admissions. Table 4.2 shows the percentage of adult patients who skip nine or more hospitals to obtain hospital care, by area of the county, insurance type, and admission type. There is a countywide gradient across insurance categories for adult patients, although only for those requiring emergency admission. This countywide gradient is entirely the result of much sharper differences in the southern and the western parts of the county between commercially insured patients and those insured by Medicaid or uninsured (see Figure 4.3). A sharp gradient also applies to patients in the south and the west who are admitted for urgent or elective purposes, although in these cases, Medicaid patients behave more like the commercially insured than the uninsured.

Some of the percentages of patients skipping many hospitals are quite high. Notably, 67 percent of uninsured urgent/elective admission adult patients in the western area do so. This is sufficient to raise the fraction of all uninsured adults that area who skip many hospitals to more than half (see Table 4.2).

Table 4.2

Adult Travel Patterns by Admission Category, Miami-Dade County, 1999

Admission Category/ Insurance Type	All Adult Discharges: Total Patients	All Adult Discharges: % at Prox. 10+ Hospitals	All Adult Discharges: Significant Difference	Adult Cardiac Discharges: Total Patients	Adult Cardiac Discharges: % at Prox. 10+ Hospitals	Adult Cardiac Discharges: Significant Difference
All Miami-Dade County						
Emergency						
Commercial	21,312	18.85	a*** b***	1,811	16.51	b***
Medicaid	15,998	23.41	a*** c***	1,085	17.42	c**
Uninsured	15,902	25.32	b*** c***	954	22.64	b*** c**
Total	53,212			3,850		
Urgent/elective						
Commercial	36,238	30.67	a*** b***	1,359	34.00	a*
Medicaid	13,703	29.10	a*** c***	388	27.58	a*
Uninsured	6,300	35.32	b*** c***	281	32.74	
Total	56,241			2,028		
South Dade County						
Emergency						
Commercial	4,748	10.76	a*** b***	343	10.79	a*** b***
Medicaid	2,099	30.01	a*** c**	145	28.97	a***
Uninsured	2,212	33.86	b*** c**	106	31.13	b***
Total	9,059			594		
Urgent/elective						
Commercial	7,759	15.92	a*** b***	254	26.38	a** b**
Medicaid	2,417	20.52	a*** c***	43	41.86	a**
Uninsured	957	37.83	b*** c***	24	45.83	b**
Total	11,133			321		
West Dade County						
Emergency						
Commercial	4,143	17.84	a*** b***	339	12.68	a** b***
Medicaid	1,200	46.33	a***	65	27.69	a**
Uninsured	1,542	47.67	b***	103	41.75	b***
Total	6,885			507		
Urgent/elective						
Commercial	6,405	35.36	a*** b***	224	41.52	a** b***
Medicaid	1,325	41.21	a*** c***	28	67.86	a**
Uninsured	776	67.40	b*** c***	33	72.73	b***
Total	8,506			285		

Significance tests: a = Commercial/Medicaid comparison; b = Commercial/uninsured comparison; c = Medicaid/uninsured comparison; *p<= 0.05 ** p<= 0.01 *** p<=0.001.

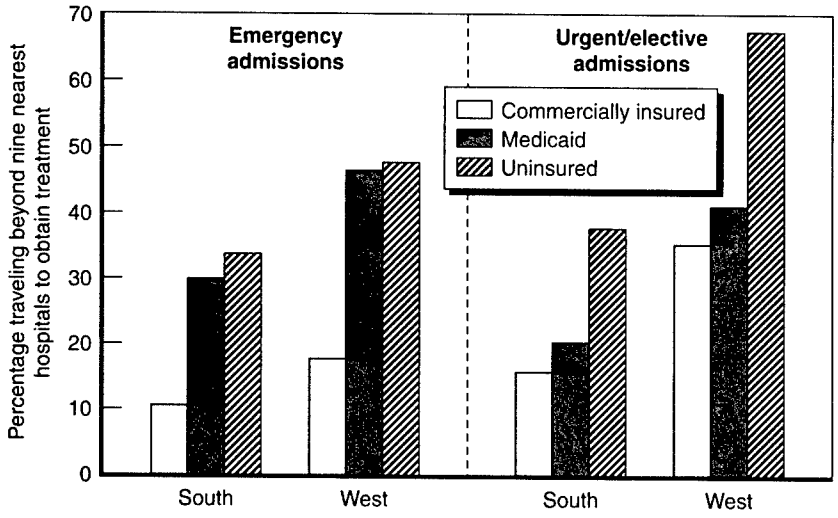

Figure 4.3—Uninsured Adults in South and West Miami-Dade County Travel Farther than the Commercially Insured, for Both Emergency and Urgent/Elective Admissions

Grouping all adult patients together, however, does not control for possible case-mix differences. For example, the reasons for admission might vary by insurance type or by region of the county. If such differences were to exist, they could affect the travel patterns. One way to control for case-mix differences is to identify patients who have relatively homogeneous diagnoses.

For this subanalysis, we identified adult patients who were admitted for cardiac conditions other than myocardial infarction (heart attack). We excluded heart attack because current practice dictates that heart-attack patients be admitted to the closest hospital. (Recall that we exclude transfer patients, so the sample does not include patients who were stabilized at local hospitals and then transferred for specialized procedures.)

The data for cardiac patients are presented in the rightmost three columns of Table 4.2. Except for the lower levels of statistical significance (the sample size is smaller), the results are qualitatively similar to those across diagnoses: Medicaid and uninsured patients are more

likely to skip nine or more hospitals than their commercially insured neighbors. (Once again, the exception is urgent and elective admissions across the county.) This suggests that case-mix variation across insurance type or region is not responsible for the differences in travel patterns.

Travel Patterns for Pediatric Patients

All hospitals have facilities to provide care for pediatric patients and thus are capable of handling emergency pediatric admissions. However, for conditions that permit planned admissions, there may be a preference for hospitals that serve a large number of pediatric patients. We identified ten hospitals in Miami-Dade County that treated at least 1 percent of pediatric discharges in the county, and we restricted our analysis of pediatric patients to those ten.

Travel patterns for pediatric patients across all admission categories display somewhat different trends than do those for adults (compare Table 4.3 with Table 4.1). Most of the differences in trends, however, are for comparisons with fairly similar percentages. Where the differences are larger, the relations are the same. Uninsured pediatric patients in western Dade are less likely to go to one of the two nearest hospitals than are insured patients. In both southern and western Dade, uninsured pediatric patients are more likely to skip many hospitals than are Medicaid patients, who are more likely to travel farther than the commercially insured.

For children requiring emergency admissions, there is little difference among insurance types in the county as a whole (see Table 4.4). More than 40 percent of children are admitted to hospitals close to their homes in an emergency. Insurance type, however, does appear to affect pediatric travel patterns for urgent or elective conditions. The travel patterns show the familiar gradient of commercially insured children admitted more frequently to hospitals close to their home, followed by Medicaid-insured children, followed by uninsured children.

Differences across payer types also appear in southern and western Dade for urgent and elective conditions, when those areas are considered separately (see Figure 4.4). But for local hospitalization, the direction of the differences is diametrically opposed between the two

Table 4.3

Pediatric Travel Patterns Across Admission Categories, Miami-Dade County, 1999

Insurance Type	Total	Proximity 1 and 2 Hospitals % of Patients	Proximity 1 and 2 Hospitals Significant Difference	Proximity 10+ Hospitals % of Patients	Proximity 10+ Hospitals Significant Difference
		All Miami-Dade County			
Commercial	9,045	36.24	a***b***	27.90	a**
Medicaid	9,708	38.90	a*** c**	29.71	a**
Uninsured	1,574	42.69	b*** c**	29.16	
Total	20,327				
		South Dade County			
Commercial	2,633	46.71	a** b**	5.66	a*** b***
Medicaid	2,291	50.59	a**	9.86	a*** c***
Uninsured	361	55.40	b**	16.90	b*** c***
Total	5,285				
		West Dade County			
Commercial	1,724	46.52	b**	10.50	a*** b***
Medicaid	874	47.71	c**	17.62	a*** c***
Uninsured	165	34.55	b** c**	32.12	b*** c***
Total	2,763				

Significance tests: a = Commercial/Medicaid comparison; b = Commercial/uninsured comparison; c = Medicaid/uninsured comparison; * p<= 0.05 ** p<= 0.01 *** p<=0.001.

regions. In the southern region, pediatric patients without health insurance are much more likely to be admitted to a local hospital than their insured counterparts (66 percent versus 38 percent). Yet for uninsured pediatric patients in the western regions, the percentage hospitalized in local hospitals is much lower than that for the commercially insured (a surprisingly low 10 percent versus, again, 38 percent). Differences across regions in nearby-admission rates for emergency conditions are modest and not statistically significant.

There are, however, striking differences across payer types, even for emergency conditions, when the measure is the percentage skipping nine or more hospitals.[10] Children without health insurance living in the western and southern areas of Dade are about four times as

[10]The reduced hospital sample consists of only ten hospitals, so nine is the maximum number of hospitals that could be skipped; patients skipping nine were thus admitted to the hospital farthest from their home.

Table 4.4

Pediatric Travel Patterns by Admission Category, Miami-Dade County, 1999

Admission Category/ Insurance Type	Total	Proximity 1 and 2 Hospitals % of Patients	Proximity 1 and 2 Hospitals Significant Difference	Proximity 10+ Hospitals % of Patients	Proximity 10+ Hospitals Significant Difference
		All Miami-Dade County			
Emergency					
Commercial	5,469	40.61	a**	26.92	
Medicaid	6,023	42.45	a**	27.94	
Uninsured	1,117	42.61		29.54	
Total	12,609				
Urgent/elective					
Commercial	3,571	29.49	a*** b***	29.43	a**
Medicaid	3,685	33.08	a*** c***	32.59	a**
Uninsured	457	42.89	c*** b***	28.23	
Total	7,713				
		South Dade County			
Emergency					
Commercial	1,760	51.14		4.26	a*** b***
Medicaid	1,272	52.99		9.83	a*** c***
Uninsured	194	45.88		19.59	b*** c***
Total	3,226				
Urgent/elective					
Commercial	872	37.73	a*** b***	8.49	b*
Medicaid	1,019	47.60	a*** c***	9.91	
Uninsured	167	66.47	b*** c***	13.77	b*
Total	2,058				
		West Dade County			
Emergency					
Commercial	1,157	50.91		7.26	a*** b***
Medicaid	578	51.56		16.61	a*** c**
Uninsured	117	44.44		26.50	b*** c**
Total	1,852				
Urgent/elective					
Commercial	567	37.57	b***	17.11	b***
Medicaid	296	40.20	c***	19.59	c***
Uninsured	48	10.42	b*** c***	45.83	b*** c***
Total	911				

Significance tests: a = Commercial/Medicaid comparison; b = Commercial/uninsured comparison; c = Medicaid/uninsured comparison; * p<= 0.05 ** p<= 0.01 *** p<=0.001.

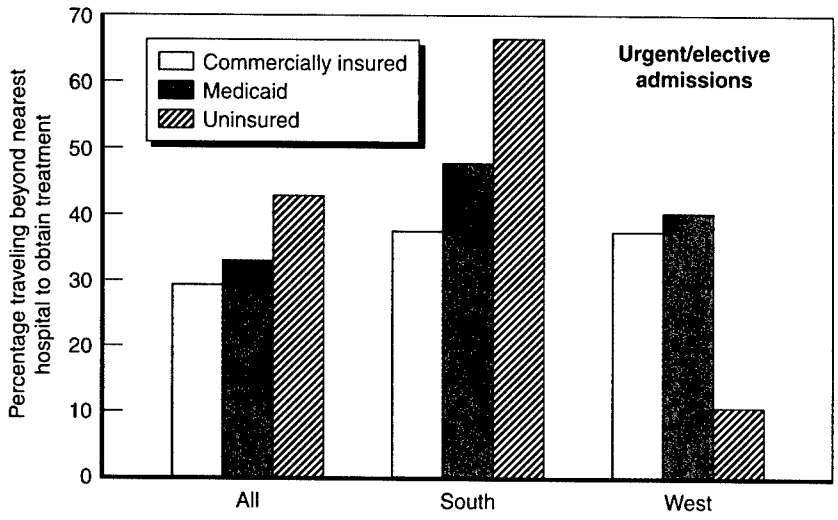

Figure 4.4—Percentages of Urgent/Elective Pediatric Admissions Occurring Close to Home Differ Dramatically Between South and West Miami-Dade

likely to skip nine or more hospitals to obtain care for emergency conditions as are commercially insured children; Medicaid-insured children are more than twice as likely to skip many hospitals as commercially insured (see Figure 4.5). Uninsured children are also more likely to skip nine or more hospitals for urgent or elective admissions than are commercially insured children. This difference is particularly stark in the western region of Dade County.

HOSPITAL DESTINATIONS

Given the differences observed in travel patterns, where are people going for their hospital care? Concentrating on the two outlying regions of the county, we first look at western Dade. Figure 4.6 shows the top five hospital destinations for adult patients who skipped nine or more hospitals for emergency admissions. As can be seen, JMH is the most frequent hospital destination for patients across the three insurance categories, especially for Medicaid-insured or uninsured patients.

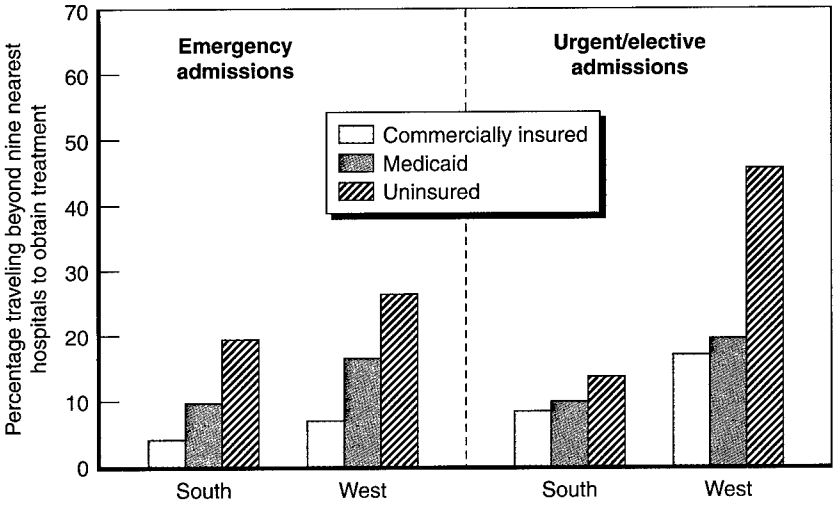

Figure 4.5—Uninsured Children in South and West Miami-Dade Travel Farther than the Commercially Insured, for Both Emergency and Urgent/Elective Admissions

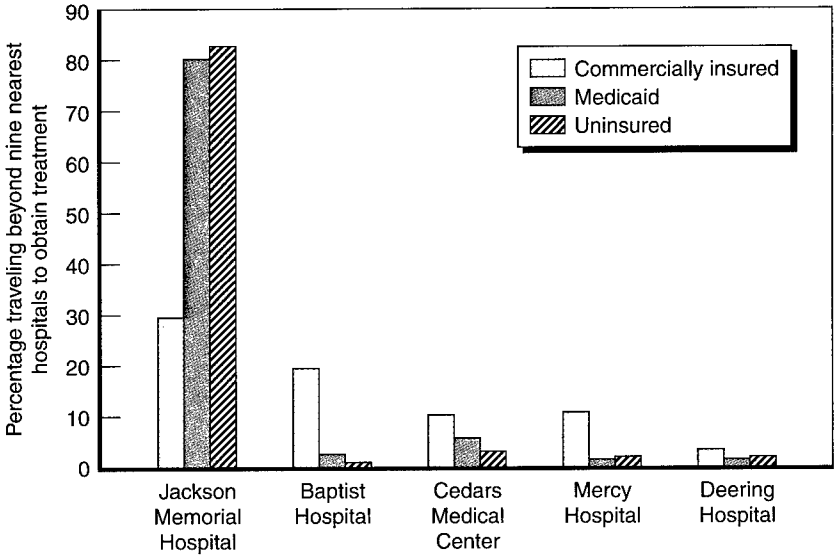

Figure 4.6—Hospital Destinations for Adult Patients Who Skipped Nine or More Hospitals for Emergency Admissions, Western Dade County

Similar patterns exist for adult urgent/elective conditions, and emergency cardiac patients. For all payers, JMH is always the dominant destination when persons skip nine or more hospitals, and the relative representation across payers again shows that Medicaid patients and those without insurance disproportionately receive their care there.

For all payer types, JMH is the most frequent destination for children from the south and the west who skip nine hospitals for their care. Among children hospitalized close to home, Baptist Hospital treats the greatest number of commercially insured children in the south and the west. In the west, Miami Children's Hospital treats the highest percentage of Medicaid and uninsured children admitted to the first- or second-closest hospital. For children in the southern region of the county, Homestead is the hospital most frequently used by children with Medicaid, and Deering is the one most frequently used by those without insurance.[11]

SUMMARY

- Across the entire county, commercially insured, Medicaid-insured, and uninsured patients do not differ appreciably in whether they are treated at hospitals close to or far away from their homes.
- Disparities do exist, however, among patients from the southern and western parts of the county, with uninsured and Medicaid patients consistently traveling farther for care, even in emergencies, than commercially-insured patients.
- JMH is the most frequent hospital destination among patients who travel far, particularly Medicaid-insured and uninsured patients.

[11]It should be kept in mind that for hospital-specific analyses such as this, sample sizes are small, particularly those of children hospitalized far from home.

Chapter Five

CONCLUSIONS

This study addresses two interrelated questions:

- To what extent do the hospitals in Miami-Dade County share the burden of uncompensated care?
- Is the funding of uncompensated care associated with the hospital at which patients are treated?

Our analysis of hospital financial data focused on the levels of uncompensated care—that is, the sum of charity care and bad debt—that Miami-Dade hospitals provide. Charity care is care provided to persons who have no financial means or insurance to pay for it, that is, the hospital does not expect to be compensated. Bad debt, in contrast, involves some expectation of payment that ultimately is not realized. Bad debt comprises the hospital bills of self-pay patients who are found to be not eligible for state or federal programs such as Medicaid, the unpaid co-payments of persons with health insurance, and other revenue shortfalls. Like earlier researchers, we analyzed the combination of charity care and bad debt, but we separated them for cross-hospital comparisons.

The level of uncompensated care reported by hospitals in Miami-Dade County is similar to that experienced by hospitals nationally. All hospitals in Miami-Dade County provided some level of uncompensated care in 1999, although two investor-owned hospitals reported that they did not provide any charity care.

Depending upon how the 0.5 percent sales surtax approved in Florida in 1991 is allocated to offset the costs of charity care, the level

of uncompensated care at JMH ranges from being the highest proportion of operating expenses to being similar to that of other hospitals that provide significant amounts of such care. Thus, the results of our hospital financial analysis rest, in part, on the intent of the half-penny sales tax. If, as is often argued, the funds are to be used to maintain trauma and specialized services at JMH, the level of uncompensated care provided there clearly dwarfs that of other hospitals. If, however, the funds are used to provide care for the county's indigent population, the level of charity care provided at JMH is similar to that of other hospitals in the county. Regardless, the surtax revenues received by JMH represent a major source of income, covering nearly one-fifth of the hospital's total operating expenses.

If the county expects not-for-profit hospitals to provide a certain level of public goods to the community, making these expectations explicit, as other states have done, would provide clear guidelines under which these hospitals' performance could be measured. Without such guidelines, it is difficult to determine what hospitals have "given" to their community in "exchange" for their tax-exempt status.

Our analysis of the extent to which the financing of indigent care affected geographic access examined patients' travel patterns. This was done to determine whether there were differences across insurance status (commercially insured, Medicaid-insured, and uninsured) in the proportion of patients who were hospitalized close to their homes. Using patient discharge data, we found that patients in the southern and western areas of the county who did not have health insurance traveled farther from their homes to get care than those who were commercially insured. Moreover, this difference existed for both emergency and urgent/elective admissions and for both adult and pediatric patients.

We did not interview patients for this study; our conclusions are derived from publicly available data. Thus, we do not know exactly why individual patients were hospitalized in particular hospitals. Patients may select a particular hospital because of proximity to home, quality of care, admitting privileges of their doctor, insurance-plan constraints, restrictions based on ability to pay, and personal preferences (concerning quality, amenities, etc.), especially for urgent and

elective admissions. However, these differences should average out over large numbers of patients. We considered the possibility that differences in travel patterns could reflect differences in the type of specialty care needed; that is, if some hospitals specialized in treating particular conditions and the prevalence of such conditions differed by payer status, this might influence hospital use. To take these considerations into account, we analyzed overall adult patients, adult cardiac patients, and pediatric patients separately. We found that the travel patterns persisted across these patient types.

By law, no hospital can turn away a patient requiring emergency care; nevertheless, the uninsured are more likely to go to JMH even if they have emergency conditions. This suggests that the centralized-system approach taken by the Public Health Trust with JMH as its hub results in most uninsured and Medicaid patients going to that hospital.

The persistent need for some patients to travel outside their areas of residence for emergency care suggests that the local hospitals are not meeting the needs of the uninsured in their areas. The pressure on uninsured patients to go beyond their local hospitals may exacerbate conditions that are already highly stressful. For many families, travel out of the area of residence is difficult, and the problem is compounded in Miami-Dade County, where public transportation is not well distributed. We may conclude from these findings that a need exists for more resources to provide uncompensated care beyond the main metropolitan (northeastern) area of the county.

Finally, it is important to note that more than half of the hospitals in Miami-Dade County are for-profit, and as noted above, two report that they provide no charity care. When the proportion of not-for-profit hospitals in an area decreases, the burden of uncompensated care, especially charity care, is borne by fewer hospitals. Not only can this lead to financial stress for these hospitals, it further reduces the number of hospitals at which uninsured patients may receive care.

Our analysis suggests the following issues and policy options that might be considered by Miami-Dade County by policymakers, stakeholders, and community members.

Reduce the number of uninsured persons in the county.

- Increase the enrollment of persons into Medicaid and other state and federal programs. Much effort is currently being devoted to increasing enrollment for children, as evidenced by the relatively small numbers of uninsured children who are hospitalized.
- Expand Medicaid and other public programs to include more adults. Our analysis clearly shows that many uninsured adults are being hospitalized, and their lack of health insurance affects their geographic access to care. Undoubtedly, some of the patients receiving uncompensated care are eligible under the current Medicaid program or under allowed expansions. Some level of compensation is preferable to no compensation.

Revisit the financing of health care for the indigent.

- Reconsider the intent of the half-penny sales tax and, in light of this analysis and any other pertinent facts, either endorse its current allocation or seek ways to alter it. The $142 million in surtax is insufficient to cover the cost of uncompensated care provided by the county's 24 acute-care hospitals.
- Explore ways to increase the distribution of care and funds for care for the uninsured throughout the county. Policymakers should consider having the county provide or subsidize health insurance that would enable patients to obtain care wherever they choose, with the assurance that reimbursement will follow.

Consider the role of community benefits in the county and their impact on the provision of indigent care.

- Clarify the community's sentiment about specifying levels of community benefits that nonprofit agencies must provide. Does the county want to rely on the quid pro quo of tax exemption and provision of charity care to maintain the safety net? Miami-Dade County should consider detailing explicitly the level of community benefits it expects from nonprofit entities. How much charity care could be provided by a community benefits program?

Monitor the dynamics of hospital-care provision in the county and publicize any changes.

- During the period in which these analyses were conducted, the Public Health Trust and the Jackson Health System purchased Deering Hospital, located in the South Dade region. This purchase will bring this hospital into the county system. Assuming that patients are well informed of this change, Deering should provide some relief for uninsured patients who currently travel long distances to JMH. It may also provide relief to Homestead Hospital, also located in South Dade, which provides a high level of uncompensated care. When data become available, analysis of travel patterns in South Dade will show whether the introduction of another public hospital brings the expected relief to Homestead Hospital and to uninsured patients.

APPENDIX

Table A.1

Top 10 ICD 9 Codes for Emergency, Urgent, and Elective Admissions for Adult Patients, Miami-Dade County, 1997–1998

	Emergency		Urgent		Elective	
Rank	**Code**	**Count**	**Code**	**Count**	**Code**	**Count**
1	786.5 - Chest pain	6436	650 - Normal delivery	5641	650 - Normal delivery	3367
2	42 - HIV	4444	654.2 - Previous cesarean delivery	3232	654.2 - Previous cesarean delivery	2305
3	428.0 - Congestive heart failure	3620	664.0 - First-degree perineal laceration	2333	295.3 – Schizophrenia, paranoid type	2077
4	295.3 - schizophrenia, paranoid type	3097	295.3 - Schizophrenia, paranoid type	2034	414.0 - Coronary atherosclerosis	1813
5	414.0 - Coronary atherosclerosis	2506	644.2 - Early onset of delivery	1760	218.9 - Leiomyoma of uterus, unspecified	1767
6	486 - Pneumonia, organism unspecified	2450	414.0 - Coronary atherosclerosis	1486	V58.1 - Chemotherapy	1744
7	491.2 - Obstructive chronic bronchitis	1882	663.3 - Other and unspecified cord entanglement, without mention of compression	1411	295.7 - Schizoaffective type	1411
8	493.9 - Asthma, unspecified	1754	656.3 - Fetal distress	1385	V57.8 - Other specified rehabilitation procedure	1253
9	282.6 - Sickle-cell anemia	1635	295.7 - Schizophrenia, affective type	1369	664.0 - First-degree perineal laceration	1176
10	411.1 - Intermediate coronary syndrome	1527	296.2 - Major depressive disorder, single episode	1294	296.3 - Major depressive disorder, recurrent episode	1111

Table A.2

Top 10 ICD 9 Codes for Emergency, Urgent, and Elective Admissions for Pediatric Patients, Miami-Dade County, 1997–1998

	Emergency		Urgent		Elective	
Rank	**Code**	**Count**	**Code**	**Count**	**Code**	**Count**
1	486 - Pneumonia, organism unspecified	1917	486 - Pneumonia, organism unspecified	638	V58.1 – Chemotherapy	403
2	493.9 - Asthma, unspecified	1892	466.1 - Acute bronchiolitis	614	493.9 - Asthma, unspecified	180
3	466.1 - Acute bronchiolitis	1368	276.5 - Volume depletion	589	466.1 – Acute bronchiolitis	178
4	276.5 - Volume depletion	1211	V58.1 - Chemotherapy	542	650 – Normal delivery	177
5	799.0 - Asphyxia	976	493.9 - Asthma, unspecified	500	486 – Pneumonia, organism unspecified	156
6	282.6 - Sickle-cell anemia	848	296.2 - Major depressive disorder, single episode	391	276.5 – Volume depletion	111
7	599.0 - Urinary tract infection, site not specified	813	650– Normal delivery	330	737.3 – Kyphoscoliosis and scoliosis	100
8	540.9 – Appendicitis without mention of peritonitis	617	296.3 - Major depressive disorder, recurrent episode	275	474.1 - Hypertrophy of tonsils and adenoids	99
9	558.9 - Other and unspecified noninfectious gastroenteritis and colitis	586	558.9 - Other and unspecified noninfectious gastroenteritis and colitis	263	304.3 – Cannabis dependence	93
10	780.3 – Convulsions	552	599.0 - Urinary tract infection, site not specified	205	V57.8 – Other specified rehabilitation procedure	91

Table A.3

1997 Estimated Cost of Uncompensated Care, Compiled by the Florida Hospital Association (FHA)

Hospital	Owner	Total Patient Service Revenue	Total Operating Expenses	Cost-to-Charge Ratio	Bad Debt	Charity Care, Hill Burton Program	Charity Care, Other	Restricted Funds for Indigent Care	Unrestricted Local Gov't. Tax Revenue and Appropriated Funds	Estimated Cost of Uncompensated Care
Aventura Hospital and Medical Center	Investor-owned	302,139,734	78,911,430	0.2612	12,328,526	0	2,721,263	0	0	3,930,633
Baptist Hospital of Miami, Inc.	Not-for-profit	524,612,061	230,967,467	0.4403	18,608,009	0	6,747,641	0	0	11,163,164
Bascom Palmer Eye Institute	Not-for-profit	55,773,268	30,216,705	0.5418	2,202,465	0	756,133	0	0	1,602,902
Cedars Medical Center	Investor-owned	503,863,942	136,780,500	0.2715	14,360,451	0	8,734,337	0	0	6,269,384
Coral Gables Hospital	Investor-owned	120,200,314	50,813,633	0.4227	4,090,146	0	1,149,908	0	0	2,215,187
Deering Hospital	Investor-owned	144,302,643	56,809,168	0.3937	10,108,147	0	2,663,456	0	0	5,027,934
Healthsouth Doctors' Hospital	Investor-owned	130,967,591	64,286,900	0.4909	5,924,422	0	0	0	0	2,908,068
Hialeah Hospital	Investor-owned	174,553,798	66,343,335	0.3801	12,588,626	0	1,932,311	0	0	5,519,029
Homestead Hospital	Not-for-profit	88,555,437	34,295,443	0.3873	9,496,161	3,295,974	0	0	0	4,954,094

Table A.3 (continued)

Hospital	Owner	Total Patient Service Revenue	Total Operating Expenses	Cost-to-Charge Ratio	Bad Debt	Charity Care, Hill Burton Program	Charity Care, Other	Restricted Funds for Indigent Care	Unrestricted Local Gov't. Tax Revenue and Appropriated Funds	Estimated Cost of Uncompensated Care
Jackson Memorial Hospital	Government	1,280,757,149	639,904,193	0.4996	18,994,364	0	300,579,557	5,895,459	157,907,331	74,819,469
Kendall Medical Center	Investor-owned	299,879,928	92,463,245	0.3083	13,767,351	0	4,888,682	0	0	5,752,293
Larkin Hospital	Investor-owned	44,953,440	25,678,004	0.5712	903,196	0	0	0	0	515,918
Mercy Hospital	Not-for-profit	298,161,518	139,033,720	0.4663	7,134,000	0	3,625,324	0	0	5,017,109
Miami Children's Hospital	Not-for-profit	266,399,398	151,970,612	0.5705	9,387,176	0	4,458,833	0	0	7,898,616
Miami Heart Institute	Investor-owned	271,754,732	100,274,861	0.3690	6,823,996	0	2,818,653	0	0	3,558,044
Mount Sinai Medical Center	Not-for-profit	539,850,523	225,126,040	0.4170	10,673,854	0	7,997,279	0	0	7,786,152
North Shore Medical Center	Investor-owned	123,999,840	55,916,613	0.4509	8,546,002	0	3,623,116	0	0	5,487,554
Palm Springs General Hospital	Investor-owned	125,621,793	45,502,942	0.3622	4,814,324	0	1,297,084	0	0	2,213,685
Palmetto General Hospital	Investor-owned	329,003,981	119,580,846	0.3635	13,765,810	0	4,216,580	0	0	6,535,937
Pan American Hospital	Not-for-profit	140,908,659	56,059,810	0.3978	5,546,294	0	932,293	0	0	2,577,474
Parkway Regional Medical Center	Investor-owned	284,595,218	100,076,191	0.3516	17,150,075	0	2,331,707	0	0	6,850,651

Table A.3 (continued)

Hospital	Owner	Total Patient Service Revenue	Total Operating Expenses	Cost-to-Charge Ratio	Bad Debt	Charity Care, Hill Burton Program	Charity Care, Other	Restricted Funds for Indigent Care	Unrestricted Local Gov't. Tax Revenue and Appropriated Funds	Estimated Cost of Uncompensated Care
Parkway Regional Medical Center West	Investor-owned	37,325,844	20,588,673	0.5516	5,845,081	0	247,428	0	0	3,360,585
South Miami Hospital	Not-for-profit	303,577,265	132,781,617	0.4374	10,307,956	0	2,694,652	0	0	5,687,209
South Shore Hospital/ Medical Center	Not-for-profit	68,160,379	34,650,100	0.5084	343,310	0	2,835,000	0	0	1,615,730
University of Miami Hospital/Clinics	Not-for-profit	107,809,128	55,028,175	0.5104	3,546,272	0	3,570,000	0	0	3,632,303
Vencor Hospital Coral Gables	Investor-owned	51,660,686	13,536,235	0.2620	0	0	355,753	0	0	93,215
Westchester General Hospital	Investor-owned	71,724,249	30,550,364	0.4259	1,796,022	0	721,276	0	0	1,072,223

NOTES: Data compiled by FHA from Agency for Health Care Administration 1997 hospital financial data, using hospitals' fiscal year ending during calendar year 1997, extracted from Health Policy Authority report by Hoo-you and Lucia (1999).

The FHA has developed the following formula to arrive at the estimated cost of uncompensated care: $(E*(F + G + H)) - (I + (0.5*J)) = K$, where E = cost/charge ratio, F = bad debt, G = Hill Burton charity care, H = other charity care, I = restricted funds, J = unrestricted funds, and K = estimated cost of uncompensated care. Using Jackson Memorial Hospital as an example:

$(0.4996*(18,994,364 + 0 + 300,579,557)) - (5,895,459 + (0.5*157,907,331)) = \$74,819,469$

Table A.4

1999 Estimated Cost of Uncompensated Care, Compiled by the Florida Hospital Association (FHA)

Hospital	Owner	Total Patient Service Revenue	Total Operating Expenses	Cost-to-Charge Ratio	Bad Debt	Charity Care, Hill Burton Program	Charity Care, Other	Restricted Funds for Indigent Care	Unrestricted Local Gov't. Tax Revenue and Appropriated Funds	Estimated Cost of Uncompensated Care
Aventura Hospital and Medical Center	Investor-owned	353,117,423	86,830,602	0.2459	16,081,112	0	2,363,362	0	0	4,535,445
Baptist Hospital of Miami, Inc.	Not-for-profit	684,960,245	262,539,230	0.3833	18,112,337	0	6,605,897	0	0	9,474,281
Anne Bates Leach Eye Institute/ Bascom Palmer Eye Institute	Not-for-profit	64,997,251	40,433,903	0.6221	3,651,316	0	734,820	0	0	2,728,555
Cedars Medical Center	Investor-owned	556,636,611	142,868,077	0.2567	14,552,114	0	11,883,512	0	0	6,785,050
Coral Gables Hospital[a]	Investor-owned	107,314,465	34,503,236	0.3215	3,125,160	0	292,840	0	0	1,098,939
Deering Hospital	Investor-owned	148,471,518	57,882,045	0.3899	9,211,587	0	3,788,937	0	0	5,068,291
Healthsouth Doctors' Hospital	Investor-owned	153,701,388	68,231,135	0.4439	7,986,356	0	0	0	0	3,545,304
Hialeah Hospital	Investor-owned	201,080,646	64,485,647	0.3207	10,290,369	0	1,373,458	0	0	3,740,536
Homestead Hospital	Not-for-profit	112,810,626	37,262,315	0.3303	13,975,451	0	7,716,289	0	0	7,164,967

Table A.4 (continued)

Hospital	Owner	Total Patient Service Revenue	Total Operating Expenses	Cost-to-Charge Ratio	Bad Debt	Charity Care, Hill Burton Program	Charity Care, Other	Restricted Funds for Indigent Care	Unrestricted Local Gov't. Tax Revenue and Appropriated Funds	Estimated Cost of Uncompensated Care
Jackson Memorial Hospital	Government	1,433,236,338	713,959,305	0.4981	27,054,885	0	328,316,613	0	141,989,707	106,031,629
Kendall Medical Center	Investor-owned	343,362,257	98,741,627	0.2876	15,635,687	0	6,763,645	0	0	6,441,437
Larkin Hospital	Investor-owned	58,510,583	25,350,517	0.4333	(1,228,937)	0	0	0	0	(532,454)
Mercy Hospital	Not-for-profit	99,585,309	48,397,858	0.4860	2,609,785	0	1,201,703	0	0	1,852,360
Miami Children's Hospital	Not-for-profit	294,848,916	139,862,904	0.4744	8,738,342	0	3,303,000	0	0	5,711,865
Miami Heart Institute/Mount Sinai	Investor-owned	275,142,775	94,146,758	0.3422	7,883,707	0	2,006,503	0	0	3,384,175
Mount Sinai Medical Center	Not-for-profit	567,840,592	238,209,446	0.4195	14,020,821	0	7,146,617	0	0	8,879,752
North Shore Medical Center	Investor-owned	211,007,974	72,007,171	0.3413	9,261,376	0	4,646,796	0	0	4,746,210
Palm Springs General Hospital	Investor-owned	136,362,940	51,035,731	0.3743	6,407,702	0	866,997	0	0	2,722,657
Palmetto General Hospital	Investor-owned	393,619,627	103,768,850	0.2636	16,074,073	0	2,674,220	0	0	4,942,560
Pan American Hospital	Not-for-profit	162,966,291	69,428,555	0.4260	4,744,905	0	1,380,320	0	0	2,609,531

Table A.4 (continued)

Hospital	Owner	Total Patient Service Revenue	Total Operating Expenses	Cost-to-Charge Ratio	Bad Debt	Charity Care, Hill Burton Program	Charity Care, Other	Restricted Funds for Indigent Care	Unrestricted Local Gov't. Tax Revenue and Appropriated Funds	Estimated Cost of Uncompensated Care
Parkway Regional Medical Center[a]	Investor-owned	224,243,644	69,642,287	0.3106	20,308,866	0	1,549,242	0	0	6,788,369
South Miami Hospital	Not-for-profit	383,624,284	152,295,242	0.3970	10,864,585	0	4,290,615	0	0	6,016,472
South Shore Hospital/Medical Center	Not-for-profit	71,242,083	36,223,628	0.5085	295,719	0	1,048,967	0	114,825	626,304
University of Miami Hospital/Clinics	Not-for-profit	140,441,738	63,932,059	0.4552	2,258,273	0	4,270,592	0	0	2,972,078
Vencor Hospital Coral Gables	Investor-owned	47,333,169	14,372,652	0.3036	3,048,593	0	1,124,672	0	0	1,267,206
Westchester General Hospital	Investor-owned	71,564,939	31,068,320	0.4341	2,551,024	0	742,208	0	0	1,429,683

NOTES:Data compiled by FHA from Agency for Health Care Administration 1999 Hospital Financial Data using hospitals' fiscal year ending during calendar year 1999.

[a]Hospitals with incomplete financial reporting as of May 2001.

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